THE CANADIAN NURSE

VOLUME 56 **NUMBER 11**
NOVEMBER 1960

964 Between Ourselves
966 Pharmaceuticals and other products
970 Random Comments
977 The Nurse Consultant .... *S. Nixon*
979 Anemia .... *A. Zipursky*
981 Food-Borne Diseases .... *J. E. Davies*
985 Interviewing the Patient about Diets .... *B. Thomas*
988 In Memoriam
989 What is the Sodium Restricted Diet? .... *V. M. Bruce and E. Feniak*
992 Adult Requirement for Calcium .... *E. Feniak*
995 A Capricious Appetite .... *M. G. Groome*
997 The Reluctant Patient .... *E. Robinson*
999 Concepts of Nursing .... *F. E. Elliott*
1004 Nursing across the Nation
1006 13th International Congress on Occupational Health .... *J. E. MacGregor*
1010 Intergroup Relations in Occupational Health Nursing .... *C. Epstein*
1022 Nursing Profiles
1030 Book Reviews
1035 Employment Opportunities
1056 Official Directory

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
For subscribers in Canada, in combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
Make cheques and money orders payable to The Canadian Nurse.
Change of address: Four weeks' notice and the *old* address as well as the new are necessary.
Not responsible for Journals lost in mail due to errors in address.
Authorized as Second-Class Mail, Post Office Department, Ottawa.
Member of Canadian Circulations Audit Board.

Between Ourselves

There is a well-known saying to the effect that if you want to have a job done quickly and thoroughly, try to find a very busy person. She will almost always find a way to fit a new assignment into an already full program.

Certainly, this comment is applicable to our guest editor, SHEILA MARGARET NIXON, A.R.R.C. When, nearly two years ago Miss Nixon accepted the obligation to serve as Editorial Adviser to *The Canadian Nurse* for the province of Manitoba, she was the director of nursing of the 232-bed Children's Hospital in Winnipeg and first vice-president of the Manitoba Association of Registered Nurses. Now, though she has moved into the presidency of the MARN and is nursing consultant with the Manitoba Hospital Services Plan she is still our Adviser. In that capacity, Miss Nixon secured the cooperation of the group of medical and other personnel who have contributed most of the articles on aspects of nutrition that comprise this issue.

Miss Nixon had already had a host of interesting experiences before she began her nurse's training at Toronto General Hospital. During World War II, she gave up the business career she was building for herself to join the Women's Division of the Royal Navy. Her decoration was awarded for meritorious service with the British Red Cross in Egypt and England. After graduating from T.G.H., Miss Nixon went directly to university and secured her Bachelor of Science degree from the University of Western Ontario, followed by her Master of Arts from Teachers College, Columbia University. A member of both the Winnipeg Philharmonic Choir and her own church choir, she still finds time for many sidelines of interest — not the least of which is solving difficult crossword puzzles!

* * *

Why should we devote almost all of an issue to a variety of aspects of nutrition? Every adult has some knowledge of foodstuffs, of the importance of a balanced diet that contains adequate quantities of vitamins and minerals, of the risks inherent in unwise reducing diets, of the various dietary fads that offer panaceas for "hidden hungers." But we question if even nurses have ever stopped to think of the multitude of sources of sodium, for instance, that the patient on a sodium-restricted diet must avoid. It certainly requires much more care than just to eliminate common table salt — sodium chloride.

And what about food poisoning? That oldtime bogey called "ptomaine poisoning" still pops up now and then in the daily press — and occasionally in a nurse's conversation — despite the fact their scientific background of information should remind them that the ptomaines are the end products of the decomposition of proteins. They should never be confused with those bacterial products that cause food poisoning.

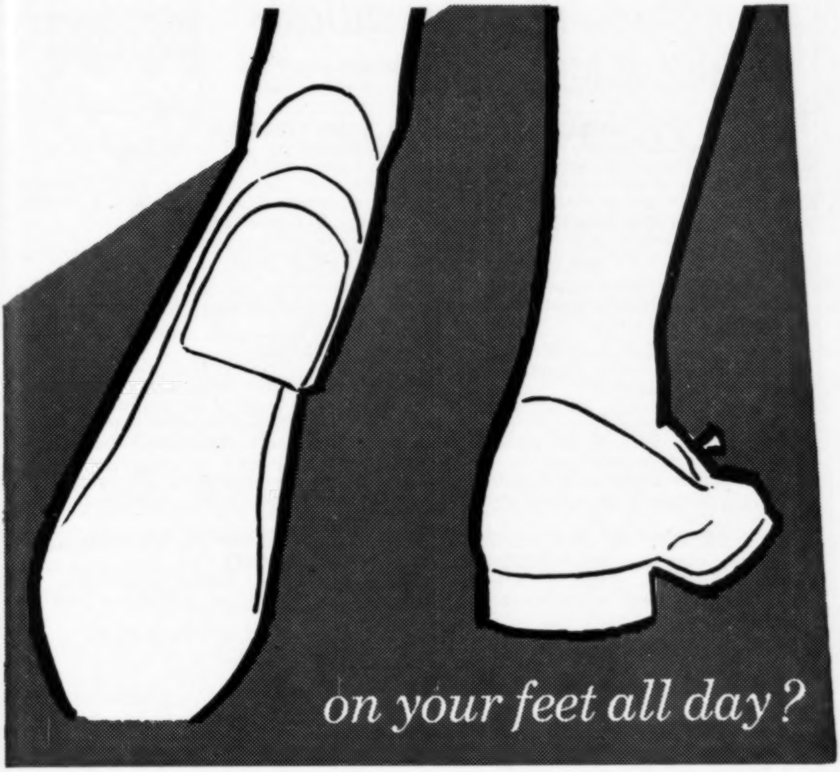
* * *

The author of "A Capricious Appetite" has some very definite ideas on the role of the married nurses in the community. We have suggested that she write another article for us in the near future outlining the ways in which she thinks these capable women who are no longer active in nursing might put their knowledge and abilities to work in their own neighborhoods. Watch for another article by MRS. MARY GROOME next year, we hope.

* * *

The **Cumulative Index,** listing all of the articles that were published between January 1955 and December 1959, by author, title and topic, is now ready for distribution. While its greatest usefulness is undoubtedly in the school of nursing library, individual subscribers may also procure a copy by completing the form appearing on page 969. A word of warning! Only 315 copies of this Cumulative Index have been prepared. Don't miss yours because you waited too long in ordering it. The price is $4.00.

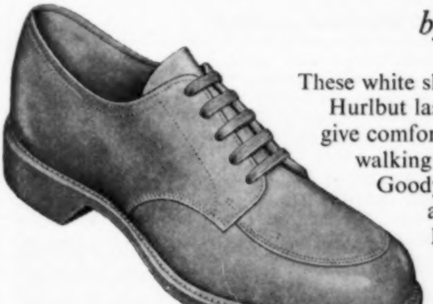
One of the few remaining chores of cooking is scouring pots and pans, especially if they have burned dry. A new compound called *Stik-free* when applied to roasting and baking pans, ovens, griddles, waffle irons etc., and baked on for one hour at 400°F, will permit washing of a burned pan with soap and water, with no scouring. One generous coating will last from three to six months.


on your feet all day?

Enjoy the comfort of

WHITE UNIFORM OXFORDS

by **Savage**



These white shoes are made over the famous Hurlbut last—a last especially designed to give comfort and support to feet that are walking and standing most of the time. Goodyear welts, chrome leather soles and a choice of military or flat heels. All sizes and widths . . . all *very* smart in appearance.

About $9.95 — $10.95

Sanitized* for lasting hygienic protection

Pharmaceuticals

and other products

AMBAR EXTENTABS NOS. 1 AND 2 (ROBINS)

Indications—In obesity control — appetite suppressant and mood ameliorating — modifies the emotional factors often involved in overeating.

Description—Each extended action tablet contains: Extentabs No. 1 — (formerly Extentabs) methamphetamine HCl 10 mg., phenobarbital 64.8 mg. (1 gr.). Extentabs No. 2 — methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.).

Administration—One before breakfast or 12 hours before retiring.

BETADINE OINTMENT (TAILBY-NASON)

Indications—Mycotic and bacterial skin infections.

Description—Polyvinylpyrrolidone-iodine complex (povidone-iodine), topical bactericidal agent, in ointment form, non-irritating, nonstaining.

CEEPLUS (CANADA PHARMACAL)

Indications—Vitamin therapy where high doses of A and C are needed. May be useful where a deficiency is causing general debility, skin and mucous membrane affections, hemorrhagic tendencies of the gums and skin, etc. Also indicated in pre- and postsurgical cases, peptic ulcers and second to third degree burns to hasten wound healing and minimize danger of hemorrhage. May be useful in the treatment of various dermatoses, such as acne, etc.

Description—Each tablet contains: vitamin A 10,000 units, vitamin C 300 mg., vitamin B_1 5 mg., vitamin B_2 5 mg., vitamin B_6 2 mg., niacinamide 15 mg., calcium d-pantothenate 10 mg.

Administration—One or more tablets daily as the clinical conditions indicate.

DECAGESIC (MERCK, SHARP & DOHME)

Indications—For symptomatic treatment of rheumatic and arthritic conditions.

Description—Each tablet contains: dexamethasone 0.1 mg., acetylsalicylic acid 300 mg., dried aluminum hydroxide gel 60 mg.

Administration—Recommended dosage is 1 or 2 tablets, 3 or 4 times daily.

DECLOMYCIN (LEDERLE)

Indications—Infections due to a wide range of microorganisms.

Description—Demethylchlortetracycline, new broad spectrum antibiotic with antimicrobial range similar to tetracycline, but provides greater therapeutic effect than tetracycline with a lower dose, and more sustained antibacterial activity in the blood.

Administration—Adults: 600 mg. per day to be given 150 mg. q.i.d. or 300 mg. b.i.d. Infants and children: daily dosage, 3-6 mg. per pound of body weight divided into 2 or 4 doses.

EMPRAZIL (BURROUGHS WELLCOME)

Indications—For symptomatic relief of the common cold.

Description—Each tablet contains: Sudafed brand pseudoephedrine HCl 20 mg., Perazil brand chlorcylizine HCl 15 mg., Empirin (phenacetin) 150 mg., acetysalicylic acid 200 mg., caffeine 30 mg.

Administration—Adults and older children: 1 or 2 tablets t.i.d. as required. Children 6 to 12 years: one tablet t.i.d. as prescribed.

MEGACILLIN 250 (PEDIATRIC) (FROSST)

Indications—For the treatment of infections caused by organisms sensitive to penicillin including staphylococcic, streptococcic, pneumococcic, gonococcic infections; for the prevention of secondary infection in influenza, measles, whooping cough, etc., and for prophylaxis following an attack of acute rheumatic fever.

Description—Each 5 cc. teaspoonful contains benzathine penicillin-G 250,000 I.U.

Administration—Children 2 to 6 years of age: ½ teaspoonful 3 or 4 times daily; for older children and adults; one teaspoonful 3 or 4 times daily, as the severity of the infection indicates.

MELLARIL (SANDOZ)

Indications—For the treatment of mental and emotional disturbances — anxiety, apprehension and tension; acute, chronic and severe psychoneuroses; pre- and postoperative apprehension and agitation; acute and chronic schizophrenia, manic psychoses and alcoholism; behavior problems in children and problems in senile patients; intractable pain and gastrointestinal complaints.

Description—10 mg., 25 mg. and 100 mg. tablets of thioridazine hydrochloride, a new phenothiazine derivative.

Administration—Adults: Mental and emotional disturbances, *mild* — 10-20 mg. b.i.d. or t.i.d.; *moderate* — 25-50 mg. b.i.d. to q.i.d.; *severe* — 100 mg. b.i.d. to q.i.d. Children: 10 mg. b.i.d. to q.i.d. These dosages are given as a guide and should be adjusted to the individual needs of the patient.

The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

SCHOOL for GRADUATE NURSES

McGILL UNIVERSITY

PROGRAM FOR GRADUATE NURSES LEADING TO THE DEGREE OF BACHELOR OF NURSING

Two-year program for nurses with McGill Senior Matriculation or its equivalent. Three-year program for nurses with McGill Junior Matriculation or its equivalent. In the first year students elect Public Health Nursing or Teaching and Supervision in one of the following clinical fields: Medical-Surgical Nursing, Psychiatric Nursing, Maternal and Child Health Nursing.

In the second year students elect to study in one of the following fields: Nursing Education, Administration in Hospitals and Schools of Nursing, Administration in Public Health Nursing.

PROGRAM FOR GRADUATE NURSES LEADING TO A DIPLOMA

Students are granted a diploma on the completion of the first year of the degree program. All first-year students elect to study in a particular field as stated above.

PROGRAM IN BASIC NURSING LEADING TO THE DEGREE OF BACHELOR OF SCIENCE IN NURSING

Five-year program for high-school graduates who have passed in the required papers of the McGill Junior School Examination or their equivalents. This program combines academic and professional courses with supervised nursing experience in the McGill teaching hospitals and selected health agencies. This broad background of education, followed by graduate professional experience, prepares the nurses for advanced levels of service in hospitals and community.

For further information write to:

DIRECTOR, McGILL SCHOOL FOR GRADUATE NURSES,
1266 PINE AVE. W., MONTREAL 25, QUEBEC.

McMASTER UNIVERSITY

DEGREE COURSE IN BASIC NURSING (B.Sc.N.)

A Four-Year Course designed to prepare students for all branches of community and hospital nursing practice and leading to the degree, Bachelor of Science in Nursing (B.Sc.N.) It includes studies in the humanities, basic sciences and nursing. Bursaries, loans and scholarships are available.

For additional information, write to:

School of Nursing,
McMaster University, Hamilton, Ontario.

The New York Polyclinic

MEDICAL SCHOOL AND HOSPITAL • Organized 1881

The Pioneer Postgraduate Medical Institution in America

Announces the following Courses (Six Months Duration)
for qualified Graduate Nurses

OPERATING ROOM NURSING

MEDICAL SURGICAL NURSING

OUT PATIENT DEPARTMENT NURSING

Courses include lectures by the Faculty of the Medical School and the Nursing Department

Stipend of $50.00 per month and full maintenance is provided

For information address:

Director of Nursing Education, 345 W. 50th St., New York, 19, N.Y.

COURSES
FOR
GRADUATE NURSES

in various clinical fields.

Terms begin January 9, 1961, April 3, 1961, June 26, 1961 and September 18, 1961. Rooms, meals, laundering of uniforms, and honorarium provided.

Apply to:

DIRECTOR,
COOK COUNTY SCHOOL
OF NURSING,
DEPT C., 1900 WEST POLK ST.,
CHICAGO 12, ILLINOIS

THE JOHNS HOPKINS HOSPITAL

SCHOOL of NURSING

Offers to qualified Registered Nurses a 16-week supplementary course in

OPERATIVE ASEPTIC TECHNIC

with instruction and practice in the general surgical, neurosurgical, plastic orthopedic, gynecologic, ophthalmologic, urologic and ear, nose and throat operating room services. Maintenance and stipend are provided.

For information write to:

DIRECTOR, SCHOOL OF NURSING
THE JOHNS HOPKINS HOSPITAL
BALTIMORE 5, MARYLAND, U.S.A.

DALHOUSIE UNIVERSITY

School of Nursing

COURSES OFFERED

1. **Degree Course in Basic Professional Nursing**
   Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing **and** the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.
2. **Degree Course for Graduate Nurses**
   Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.
3. **Diploma Courses for Graduate Nurses**
   (a) Public Health Nursing
   (b) Teaching in Schools of Nursing
   (c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

CUMULATIVE INDEX

1955-59

The complete listing of all articles published in The Canadian Nurse during the past five years is now on sale.

PRICE: $4.00 PER COPY

To order, complete this form:

Name ....

Address ....

....

Number of Copies ....

Amount enclosed ....

WILLS EYE HOSPITAL
Philadelphia, Penna.

The largest eye hospital in the United States offers a six-month course in ***Nursing Care of the Eye*** to *Graduates of Accredited Nursing Schools.* Operating Room Training is scheduled in the course.

- Full maintenance and a stipend of $237 per month for the first three months. $247 per month for the last three months, plus maintenance.
- REGISTRATION FEE IS $20
- Course starts **September 16th & March 16th.** Ophthalmic Nurses in great demand for hospital eye departments operating rooms & ophthalmologists' offices.

For information write to:

Director of Nurses,
Wills Eye Hospital,
1601 Spring Garden Street.
Philadelphia 30, Penna.

THE NATIONAL HOSPITAL
Queen Square, London, W.C.1., England

(MEDICAL NEUROLOGY AND BRAIN SURGERY)

ADVANCED NURSING EDUCATION

One year courses are open to graduates of accredited Schools of Nursing having good educational background.

Three months academical teaching in the School of Nursing under guidance of Sister Tutor assisted by large teaching Staff of Senior Neurologists and Neuro-Surgeons.

Eight months Clinical experience, one month vacation.

Certificate and badge of the hospital awarded to successful students. Full graduate salary paid throughout the year. This work has a special appeal to nurses interested in research and the humanitarian aspect of Nursing.

Apply to:
MATRON FOR FURTHER PARTICULARS.

Random Comments

Dear Editor:

Please find enclosed a money order for the renewal of my subscription to *l'Infirmière Canadienne.* At the same time I would like to convey my deep satisfaction in reading your pleasing and interesting journal.

After I have read it each month I always have the feeling of having spent time with an instructive and interesting good friend. I am always pleased to see it in the mail.

Please accept my grateful greetings.

YOLY COLLIER, California.

Dear Editor:

May I say how much I enjoyed the July issue of *The Canadian Nurse.*

I am a young married nurse with small children. Frequently people ask many questions concerning our work as nurses, such as communicable diseases and general questions concerning first aid treatment. I feel that many nurses like myself would appreciate articles of this nature.

I might suggest a page that would deal with "questions" and "answers" on current nursing problems. I am sure they would be extremely helpful to many nurses (especially the inactive nurses) who read the Journal.

Best wishes for the continuation of a fine magazine.

M. J. SMITH, Nova Scotia

Dear Editor:

I wish to express my admiration for the *Journal.* I hope it has a long life and that it will continue to spread its assistance and encouragement to Canadian nurses.

M. COMTOIS-CÉCYRE, Quebec

Dear Editor:

I would like to say I do enjoy the *Journal* very much. I think it does help to keep us up with nursing, especially we who are unable to nurse because of a family.

JUNE M. TAYLOR, Ontario

Dear Editor:

While doing private duty nursing in New York, I was called to nurse a man with cancer of the stomach. As soon as I came on duty he poured out his troubles to me.

His home was two miles from the hospital and his troubled and weary little wife travelled daily to visit him. He begged me not to give him any more eggnogs, which he vomited instantly. He wanted so much to go home where his wife could care for him and prepare food that he could retain. The nurses and doctors seemed too busy or disinterested to be aware of his wishes.

When his doctor visited that day I told him what the patient had said — as a result he was discharged the following day.

This narrative indicates that "patient" conditions in the hospital are very impersonal. The patient is just "another" and treated accordingly.

What has happened to our hospitals and the nurses who took the Florence Nightingale pledge? The *human touch* and the kindly approach have been replaced by speed, restlessness and commercialism. The patient, especially the poor and aged, is completely forgotten.

I fully realize that a new era is upon us, changes are imminent, and adjustments called for that we must try to make. But in doing so, let us not discard the *worthwhile* ideals of the nursing profession.

MARY R. GAVIN, P.E.I.

Dear Editor:

Since June 1959 I have received a complimentary copy of *L'Infirmière Canadienne.* I want to let you know the pleasure I have in receiving the *Journal,* which is so interesting and of such value in my work.

Thank you for your kindness, it is much appreciated.

FERNANDA ALVES DINIZ,
Regional Officer for Nursing Care,
World Health Organization,
Copenhagen, Denmark.

As Essential As Your Uniform!

Cash's WOVEN NAMES

- for marking all uniforms, clothing and other belongings.
- Permanent, easy identification. Avoid losses.
- Easily sewn on or attached with No-So Cement.

FROM DEALERS OR
CASH'S, BELLEVILLE 5, ONT.

Cash's Names
12 doz. $3.50
9 doz. $3.00
6 doz. $2.40
3 doz. $1.80
No-So Cement
35c tube

POSTGRADUATE COURSES FOR REGISTERED NURSES

Notre Dame Hospital of Montreal

- GENERAL MEDICINE
- GENERAL SURGERY
- OPERATING ROOM
- OBSTETRICS

Classes: September and March
Duration: 6 months

Substantial remuneration
Meals and laundry provided.
Ability to speak French essential.

For further information write to:

LA DIRECTRICE DU NURSING
HOPITAL NOTRE-DAME
1560 EST, SHERBROOKE,
MONTREAL, QUEBEC.

ST. JUSTINE'S HOSPITAL

OFFERS

Postgraduate courses for
REGISTERED NURSES

in

- Pediatrics
- Obstetrics

in cooperation with the Marguerite Youville Institute, and leading to a university certificate as well as a refresher course in the

- Care of the Premature Infant

in cooperation with the Minister of Health of the Province of Quebec.

For further information write to:

LA DIRECTRICE DU NURSING,
HOPITAL SAINTE-JUSTINE
3175 CHEMIN STE-CATHERINE,
MONTREAL 26.

NOVA SCOTIA SANATORIUM
KENTVILLE N.S.

Offers to Graduate Nurses a Three-Month Course in ***Tuberculosis Nursing,*** including Immunology, Prevention, Medical & Surgical Treatment.

1. Full series of lectures by Medical and Surgical staff.
2. Demonstrations and Clinics.
3. Experience in Thoracic Operating Room and Postoperative Unit.
4. Full maintenance, salary & all staff privileges.

For information apply to:

DIRECTOR OF NURSING, NOVA SCOTIA SANATORIUM, KENTVILLE, N.S.

THE WINNIPEG GENERAL HOSPITAL

Offers to qualified **Registered Graduate Nurses** the following opportunity for advanced preparation:

A six month *Clinical Course* in *Operating Room Principles and Advanced Practice.*

Course commences in JANUARY and SEPTEMBER of each year. Maintenance is provided. A reasonable stipend is given after the first month. Enrolment is limited to a maximum of six students.

For further information please write to:

DIRECTOR OF NURSING
GENERAL HOSPITAL
WINNIPEG, MANITOBA

MOUNT HAMILTON HOSPITAL

offers a three-month Postgraduate Course in Obstetric Nursing to qualified Registered Nurses.

Additional lectures in Teaching and Administration will be given in conjunction with McMaster University.

FINANCIAL ASSISTANCE AVAILABLE.

Course to commence January, April, September.

For further information apply to:

MISS ELIZABETH FERGUSON, R.N.,
SUPERINTENDENT OF NURSING,
MOUNT HAMILTON HOSPITAL,
HAMILTON, ONTARIO

THE MOUNTAIN SANATORIUM

Tuberculosis Division of the
Hamilton Health Association
offers
a two months postgraduate course in
IMMUNOLOGY
PREVENTION AND TREATMENT
of
TUBERCULOSIS

Write:
DIRECTOR OF NURSING,
BOX 590, HAMILTON, ONTARIO.

CHILDREN'S HOSPITAL OF WASHINGTON, D.C.

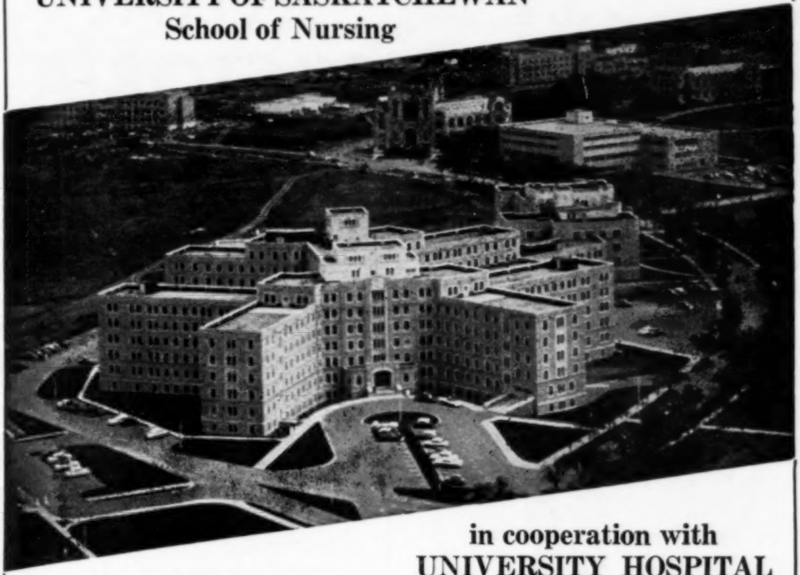
OFFERS

Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 3, May 2, August 29, 1961; January 3, May 8, 1962.

For complete information write to:

DIRECTOR OF NURSING
2125-13th STREET, N.W., WASHINGTON 9, D.C.

UNIVERSITY OF SASKATCHEWAN
School of Nursing



in cooperation with
UNIVERSITY HOSPITAL

PROGRAMS FOR GRADUATE NURSES

Teaching and Supervision

To meet the needs of nurses wishing to prepare for positions of responsibility in either teaching or supervision in Schools of Nursing.

Public Health Nursing

To meet the needs of nurses wishing university preparation for staff work in public health nursing agencies.

Administration of Hospital Nursing Service

To meet the needs of nurses preparing for head nurse, supervisory or matron positions.

This program is supported by the W. K. Kellogg Foundation.

Diplomas are granted on successful completion of the above programs and credits earned may be applied toward the degree of Bachelor of Science in Nursing.

PROGRAMS FOR HIGH SCHOOL GRADUATES

Leading to the Degree in Nursing

Students with senior matriculation may pursue a combined academic and professional program leading to the degree of Bachelor of Science in Nursing. In the final year students will elect to study Teaching and Supervision or Public Health Nursing. This broad educational background followed by graduate professional experience enables nurses to progress rapidly into positions of responsibility.

Leading to the Diploma in Nursing

A three year hospital program is conducted for students meeting the entrance requirements of the University.

For further information or inquiries about scholarships, write to:

**DIRECTOR, SCHOOL OF NURSING, UNIVERSITY OF SASKATCHEWAN,
SASKATOON, SASKATCHEWAN**

Ours are probably the slowest produced Uniforms in Canada.

It is true that we take four times longer to turn out our Uniforms, than others do.

But it is also true that our dresses are partly hand made, and are all hand finished.

They take time to make, but they also take a long time to wear out.

Made and sold only by

BLAND AND COMPANY LTD.
2048 Union Ave., Montreal, Canada

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING
MONTREAL, QUEBEC

Postgraduate Courses

1. (a) Six month clinical course in Obstetrical Nursing.
   Classes—September and February.
   (b) Two month clinical course in Gynecological Nursing.
   Classes following the six month course in Obstetrical Nursing.
   (c) Eight week course in Care of the Premature Infant.

2. Six month course in Operating Room Technique and Management.
   Classes — September and March.

3. Six month course in Theory and Practice in Psychiatric Nursing.
   Classes — September and March.

Complete maintenance or living-out allowance is provided for the full course.

Salary — a generous allowance for the last half of the course.

Graduate nurses must be registered and in good standing in their own Provinces.

For information and details of the courses, apply to:—

Miss H. M. Lamont, B.N.
Director of Nursing,
Royal Victoria Hospital
Montreal, P.Q.

From Saunders — Useful and practical texts for nurses

Martin — Diabetes Mellitus

New!—This practical manual thoroughly covers effective nursing care of the diabetic patient. Techniques and principles found here range from directions on how to recognize the symptoms of diabetes to step-by-step instructions on foot care — from explanations on how to use the ADA exchange lists to a discussion on the psychologic aspects of diabetic care in children. Emphasis throughout is on the importance of early diagnosis and possible prevention. Pertinent information covers: exchange diets — the oral hypoglycemic drugs — insulin shock in children — the diabetic driver — blood sugar test — surgery and the diabetic — pregnancy and diabetes — complications, including vascular lesions, neuropathy, etc.

By Marguerite M. Martin, R.N. 167 pages, illustrated. $3.50. *New!*

Geddes — Premature Babies

New!—Written by a skilled pediatrician, this lively little text gives a clear picture of the premature infant's physiology and the importance attached to deviations from normal behavior. The author stresses that early diagnosis of abnormalities by the physician is extremely difficult without the skilled observations of the nurse. Dr. Geddes shows just how the premature compares with his full term brother and describes problems involved from the "first breath" until the infant is able to lead a normal home life. Sound advice is given on: emergency management of cyanosis; gavage feeding; special techniques of intramuscular medications; equipment needed in the nursery; transportation of the premature; etc.

By A. K. Geddes, M.D., Associate Professor of Pediatrics, McGill University, Montreal; Physician, Montreal Children's Hospital. 215 pages, illustrated. $4.50. *New!*

Gunther — Garnsey's Dosage and Solutions

Fifth Edition!—This compact handbook gives the nurse explicit directions on every procedure concerned with the handling of powerful drugs and making up poisonous solutions. All important antiseptics and disinfectants are discussed with their principal uses. A valuable section classifies drugs according to their effects and according to therapeutic uses and doses. Coverage includes drugs acting on: skin and mucous membranes; gastro-intestinal system; nervous system; blood and circulatory system; etc. In discussing the administration of medicines, the author lists conditions which may vary the dose, such as: age of the patient, weight, sex, urgency of case, etc.

Revised by Hulda L. Gunther, B.S., R.N., Director, St. Louis Unit, Shriners Hospital for Crippled Children. 209 pages. $2.50. *Fifth Edition!*

Sutton — Workbook for Practical Nurses

Packed with useful questions and problems, this valuable workbook covers the areas of practical nursing where students need help and assistance most. Every commonly encountered nursing situation is discussed . . . from simple housekeeping — to bandaging — to collecting specimens — to nursing in emergency situations. You will find such pertinent discussions as: How does a practical nurse receive her license? What methods are used to control hemorrhage post-operatively? What is the first-aid treatment for a head injury? How can the practical nurse help ease a patient's fears during pregnancy? Where should insulin be stored?

By Audrey Latshaw Sutton, R.N., Formerly Clinical Instructor of Practical Nursing, Wilmington General Hospital, Wilmington, Delaware. 347 pages, illustrated. $3.50.

gladly sent to teachers for consideration as texts

W. B. SAUNDERS COMPANY

West Washington Square Philadelphia 5, Pa.

Canadian Representative: McAinsh & Co., Ltd., 1251 Yonge St., Toronto 7

on the run?

your

tray

needs

N.C.F. Tabsules
BRAND

to see you through...

"N.C.F." provides selected vitamin-mineral nutrients, in economical yet adequate amounts, for convenient and effective dietary supplementation.

Each daily dose of 2 "N.C.F." tabsules contains:

Ferrous sulphate BP	150 mg. (2½ gr.)
Copper sulphate	5 mg.
Magnesium stearate	12 mg.
Manganese carbonate	0.6 mg.
Vitamin A	2000 Int. Units
Vitamin D	2000 Int. Units
Bone flour	260 mg. (4 gr.)
Vitamin B_1	2 mg.
Vitamin B_2 (riboflavin)	2 mg.
Brewer's yeast concentrate	100 mg.
Niacinamide	10 mg.
Vitamin C (ascorbic acid)	50 mg.
Potassium iodide	0.4 mg.

DOSAGE: One or two tabsules daily.

Bottles of 50, 100, and 250 tabsules

Frosst
Charles E. Frosst & Co.
MONTREAL CANADA

THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 11

MONTREAL, NOVEMBER 1960

THE NURSE CONSULTANT

IN THE PAST TWO YEARS, we have seen the introduction of hospital insurance plans in many of the provinces. As nurses, we must agree with the desirability of making hospital care available to everyone who needs it, but many of us have probably had doubts about the effect of such plans on the quality of hospital services. Some people may feel alarmed by the idea that financial support by governmental agencies must entail some measure of control. Nevertheless, it is evident that the responsibilities of expenditure of public funds include assurance that all sections of the public receive, in approximately equivalent quantity and quality, the services for which they are paying.

In January, 1959 the Hon. J. Waldo Monteith said, in part:

> We have seen to it that the hospital insurance program itself will foster the continuing of improvement in hospital care. Special machinery has been built in the provincial plans for this very purpose, but this machinery cannot do the whole job. A good deal of responsibility must still rest with the medical profession and hospitals. Experience shows that high quality care can best be insured by doctors and hospital authorities working together.

Part of this "machinery" is the appointment of consultants for various

SHEILA NIXON

areas of hospital operation. Most provinces now have at least one nursing consultant. While the responsibilities and duties of this position may not be clearly defined as yet, some functions are becoming apparent.

The first duty of a consultant is to become well acquainted with the field. This means extensive visiting of hospitals; learning about the conditions under which each institution operates; getting to know the people working in them. As nursing spreads its duties into so many areas — especially in small hospitals — the consultant cannot confine her interest entirely to nursing. She must become acquainted with problems in administration, purchasing, diagnostic and treatment facilities. This inevitably leads her to a realization of the difficulties imposed by the structural limitations of many existing hospital plants. The nurse learns to read blueprints so that she may make suggestions concerning required facilities. She works with other consultants on the approval of plans for building and renovation.

While the consultant is primarily concerned with service, the preparation of people to render service inevitably becomes of interest. She must be well aware of all programs and trends, not only in the education of professional nurses, but in that of other paramedical and auxiliary personnel. When necessary, she participates in educational programs, especially institutes, workshops and conferences for people in the hospital field. She may be called upon to assist with various publications and information services. Participation in research activities may also be expected of her.

Consultation is more than a one-way activity. It is far from being the "one-man show" administration of an expert in a problem situation. A consultant should be a channel for information and ideas to and from several directions. It is essential that the nurse consultant should be in close contact with her own professional associations in order to interpret the ideas of the organized profession both to governmental officials and to hospitals. She also must take back to the individual associations the problems that belong rightfully to their jurisdiction.

The most frequent problem encountered is the lack of prepared staff. No consultant can produce them. She can, however, encourage nurses to further their preparation. She can look for people who are ready for more responsibility, and who are seeking changes in position.

The responsibility of each professional association is to bring to the attention of employing governmental departments the qualifications that they should expect of the nurses appointed to the position of consultant. Wherever possible, the association should assist in finding suitable people. Once appointed, the consultants need our support and cooperation if they are to make their best contribution to the maintenance and improvement of the standards of nursing care in our hospitals.

SHEILA NIXON
President
Manitoba Association
of Registered Nurses

Trans-Atlantic Exchange of Nurse Teachers

The Northern Ireland Hospitals Authority has been given a grant of $18,000 by the Rockefeller Foundation, New York, to meet the cost of a scheme that will provide for an exchange of nurse teachers. The two and a half year scheme will apply to the Toronto Western Hospital, the Massachusetts General Hospital, Boston and the Royal Victoria Hospital, Belfast.

Two nurse teachers from the Royal Victoria Hospital, will each spend a year on teaching duties, between Boston and Toronto. Similarly, nurse teachers from Toronto and Boston will each spend a year teaching at the other participating hospitals.

The scheme is intended to benefit the nurse teaching arrangements at the three hospitals and to produce information which will be of value to them and to other hospitals, in the instruction of student nurses.

ANEMIA

A. Zipursky, M.D.

Anemia is not a disease. It is the symptom of an underlying condition requiring careful investigation.

Etiology

Anemia may be defined as a reduction below normal of the concentration of hemoglobin in the blood. Such a definition indicates that anemia *is not a disease* but rather a single sign of disease. A fall in hemoglobin may result from a variety of disease processes. To understand the mechanism by which anemia is produced we must first understand the normal processes of red blood cell production and destruction.

The red blood cells, containing hemoglobin, are formed in the bone marrow. Iron, vitamin B_{12} and folic acid are necessary for the formation of hemoglobin and red blood cells. The cells so produced are released into the blood stream and survive for an average of 120 days. Destruction then occurs, particularly in the spleen, and the iron is saved to be used once more in hemoglobin formation. A reduction in hemoglobin concentration in the body can therefore occur for the following reasons:

I. Failure of red blood cell production.

II. Increased rate of red blood cell destruction (red cell life span is shorter than 120 days).

III. Loss of blood from the body.

I. Failure of Red Blood Cell Production

A. Nutritional failure

In certain conditions, the bone marrow may fail to produce blood simply because there are not enough nutrients available from which erythrocytes can be manufactured. In this group there are two main categories:

1. *Iron deficiency anemia*

Iron is necessary for the proper formation of hemoglobin. If iron is lost from the body (for example, through chronic blood loss) or if the demands for iron are excessive (for example, in pregnancy or rapid growth in infancy) the iron stores in the body will be depleted. There is then insufficient iron for hemoglobin formation. Since the marrow is unable to form hemoglobin properly, the red blood cells contain a decreased quantity of it and are accordingly small. When these cells are examined under the microscope they appear pale (hypochromic) and small (microcytic). Thus iron deficiency anemia is characterized as a hypochromic microcytic anemia.

2. *Deficiency of vitamin B_{12} or folic acid*

These substances are necessary for the proper development and formation of many body cells, including the red and white cells of the blood and the platelets. The formation of red cells in the absence of vitamin B_{12} or folic acid is markedly retarded. The mature erythrocytes in the circulation are very large (macrocytes). The red blood cell precursors in the marrow assume a grossly distorted appearance and are called "megaloblasts." Thus the anemia of vitamin B_{12} or folic acid deficiency is characterized as a macrocytic anemia with megaloblastic changes in the bone marrow.

Vitamin B_{12} is required in exceedingly small amounts in the diet so that a pure dietary deficiency of vitamin B_{12} almost never occurs. The absorption of vitamin B_{12} in the bowel is dependent on the presence of a specific substance liberated in the stomach and referred to as "intrinsic factor." If this substance is absent, absorption of vitamin B_{12} does not occur and anemia will develop. Primary deficiency of intrinsic factor and the resulting anemia is what we recognize as pernicious anemia. Folic acid deficiency occurs in a large variety of conditions where its absorption is interfered with (for example, sprue). Most of the folic acid required in the body can be formed in the bowel by bacterial action. If this

---

Dr. Zipursky is on the medical staff of the department of pediatrics, University of Manitoba and The Children's Hospital, Winnipeg.

is interfered with by prolonged antibiotic therapy, folic acid deficiency anemia may appear.

There are virtually no other nutritional deficiencies that commonly result in anemia in humans.

B. Bone Marrow Failure

A failure of red cell production may occur as a result of pathological processes within the bone marrow that prevent normal cell formation. Thus the marrow elements may be replaced by leukemic cells, tumor cells or fibrous tissue. They may also be destroyed by x-ray or drugs (aplastic anemia). In all of these conditions the marrow cannot form red cells but those cells that are present in the peripheral blood are of normal size (normocytic) and normal color (normochromic). The normochromic normocytic anemia under these conditions is usually associated with a depression in white blood cells and platelets.

C. Chronic Infection and Disease

In chronic infections and in certain chronic disease states (for example, rheumatoid arthritis, kidney disease or cancer) a mild anemia often develops. This is also a normochromic normocytic anemia with hemoglobin levels seldom lower than 9 gm.% (57% of normal). Anemia in these conditions appears to be due primarily to a failure in adequate red cell production by the marrow. There is seldom an associated fall in platelets or white blood cells.

II. INCREASED RATE OF RED BLOOD CELL DESTRUCTION

When anemia occurs as the result of a shortened red cell life span within the body we refer to this as a hemolytic anemia. This may result from an intrinsic defect within the red blood cell or from some factor outside the cell that results in its destruction.

The intrinsic abnormalities of the red cell are inherited defects. Often the inherited defect not only manifests as a shortened life span but also as an abnormality in red cell shape or in the type of hemoglobin. Thus the cell may be spherical (hereditary spherocytosis) or elliptical (hereditary elliptocytosis). The hemoglobin in the cell may vary from the normal type that we refer to as Hemoglobin A to an abnormal type such as Hemoglobin S — the characteristic hemoglobin found in sickle cell anemia. In these disorders the defect may be found in several members of one family. When red cell destruction is increased in these disorders, most of the destruction may occur within the spleen. When this situation occurs, splenectomy is often curative. Otherwise, there is no treatment available for these hereditary forms of hemolytic anemia.

Under certain conditions normal red blood cells can be destroyed within the body. This is referred to as an acquired hemolytic anemia. A good example of this is erythroblastosis fetalis or hemolytic disease of the newborn. In this condition, anti-Rh antibodies pass from the Rh-negative mother to the Rh-positive fetus. These antibodies actively destroy the normal red blood cells of the infant. In other instances antibodies may arise spontaneously in an apparently normal individual and cause destruction of normal red blood cells. A similar condition occurs more frequently in individuals who are already suffering from some other disease (for example, disseminated lupus erythematosus or Hodgkin's disease).

III. ANEMIA DUE TO BLOOD LOSS

This is the final and most obvious category of causes of anemia. Acute blood loss can result in the sudden appearance of anemia before the body can produce sufficient blood to replace that which has been lost. The anemia of chronic blood loss is an iron deficiency anemia.

Diagnosis

The diagnosis of the cause of anemia in a patient is dependent on a careful history, physical examination and adequate laboratory investigation. In this way the physician must endeavor to determine:

1. Has the patient lost blood? This can be determined by history and by repeated examination of the stools for occult blood.

2. Is the patient destroying his cells more rapidly than normal? In these cases jaundice may be present or there may be an increase in the products of red blood cell destruction (urobilinogen) excreted in the stool. More complex tests involving determination of the red

cell life span have become available recently. At times these are necessary to detect the presence of a hemolytic anemia.

3. Finally, is the patient able to form blood? This can be determined to some extent from an examination of the number of young red cells (reticulocytes) in the circulation. An increase in their concentration indicates increased red cell production whereas a decrease implies decreased production. An examination of a bone marrow aspirate is often helpful in that it can indicate any abnormal process within the marrow, (for example, leukemia, megaloblastic changes) that is interfering with red cell production.

One of the most important diagnostic tests in the study of anemia is an examination of the blood smear. In this way one can recognize abnormal erythrocyte shape (for example. spherocytes, elliptocytes) or abnormal size (macrocytes, microcytes). The significance of such findings has been mentioned earlier.

Treatment

There is no treatment for anemia just as there is no treatment for abdominal pain, jaundice or any other single sign or symptom of disease. Physicians do not treat signs or symptoms. They attempt to treat the disease itself. Therefore we first diagnose the cause of the anemia and then treat the disease producing it.

I should like to mention one group of diseases, the therapy of which seems most pertinent to this discussion. I refer to the nutritional deficiencies of iron, vitamin B_{12} and folic acid. In these conditions the treatment of the anemia is by specific replacement of the deficient substance. For iron deficiency anemia we prescribe iron only; for folic acid deficiency we prescribe folic acid only. The "shotgun" therapy of anemias with multivitamins and multimineral preparations is senseless, expensive and dangerous.

In conclusion, I should like to repeat that anemia is only a *sign* of disease. Its presence requires an active search for its cause. To treat anemia blindly with transfusions, medications, and so forth is wrong. The careful study of an anemia may reveal the nature of the underlying disease and it will certainly point out the most rational and direct method of therapy.

FOOD-BORNE DISEASES

J. E. Davies, M.B., B.S., L.M.C.C.

At the beginning of this century, the majority of epidemics were water-borne but as a result of improved sanitation of water supplies, this is no longer the case. Today, food is the most important factor.

In considering diseases that are food-borne, it is important to differentiate those illnesses that may arise either as a result of a variation in the quantity of food, in the composition of food or as a result of idiosyncrasy in the host. The former are essential nutritive diseases. The latter can be classified as allergic or metabolic diseases. For example, at times, urticarial rashes, migraine, gastroenteric upsets, and many other clinical syndromes may develop in certain individuals as a result of a sensitivity to a particular food. In this instance, there is nothing wrong with the food. It is simply a peculiarity of the individual. It is a situation where "one man's meat is another man's poison." The same is true in certain metabolic disorders such as celiac disease. A metabolic idiosyncrasy of the host is at fault and, in this specific instance, the protein, glutein, cannot be digested.

The operative word in this article is "borne" because food is thought of as a vehicle which, at times, can carry a noxious agent from its reservoir to the human host. It has often been

---

Dr. Davies is assistant medical health officer, City of Winnipeg.

said that, in most urban populations, there has been an actual increase in food poisoning since the last war. Certainly, there has been a change in our eating habits during the past 20 years. The increased number of catering establishments since World War II enlarged enormously the likelihood of infection. Furthermore, the mass manufacture of desiccated food products such as dried eggs and custard powders, enhance the risk. In the majority of instances, since food poisoning is often a mild disease, the health authorities are not notified. This makes it difficult to obtain an accurate overall picture of the prevalence of this complaint. There were 9,925 reported cases of food-borne diseases in the United States in 1958[1], but this figure is probably far below the actual number of cases that occurred.

Classification

Food may be contaminated by a chemical, radioactive or infected source.

Chemical and radioactive sources: In Canada, contamination from this source is largely obviated by the strict control enforced through the Food and Drug Act. The implications of the presence of radioactive particles, such as strontium 90 in milk, are only too well known. The levels of this radioactive element are being monitored all across Canada. The same strict control is apparent with regard to the chemical poisoning of food stuffs, but this is certainly not the case in many other countries in the world. The consequences of faulty supervision can be only too clearly and tragically witnessed in French Morocco today. There, in September 1959[2], as a result of the contamination of cooking oil with orthocresyl phosphate, a chemical used to lubricate turbo-jet aircraft engines, some 10,000 Moroccans were rendered pitifully and permanently paralyzed by food pollution.

Bacterial infection: In this group of diseases, there is a bacterial invasion and multiplication in the mucous membrane of the bowel with secondary spread to the mesenteric lymph nodes. In the case of typhoid there is spread to the bloodstream that produces a septicemia. The reservoirs of infection in these conditions are "carriers." These persons are usually either in a convalescent or a chronic stage of an illness. The most common mode of spread is through infection of water, milk or food.

Within the last six months there have been six cases of typhoid in Winnipeg. The disease developed in a group of school girls who had attended a Sunday School party. It later transpired that some of the egg sandwiches had been prepared by the grandmother of one of the girls. She had come in from the country to help prepare the food. She had had typhoid 30 years ago. She was later shown to be an unknown carrier but had carried on all these years without infecting either her family or her friends in the country. The removal of this lady's gall bladder resulted in a permanent cure of her carrier state.

Metazoal infection: Trichinosis is a not uncommon example of a metazoal food borne disease. It is confined to those who eat the uncooked or inadequately cooked flesh of infected animals. Last year there were six[3] reported cases in Canada, and to date

INFECTIVE AGENTS

	Types	*Sources*
A.	Bacterial infection	Bacteria that are the causes of specific infectious diseases (for example, typhoid, paratyphoid, dysentery)
B.	Metazoal infection	Metazoa that are the causes of specific metazoal diseases (for example, trichinosis)
C.	Bacterial food poisoning	1. Organisms of the Salmonella group 2. Staphylococcal infection 3. Botulism 4. Other organisms such as Clostridium *welchii*
D.	Plant and fungi	

this year the cumulative total of cases is 18.[4] The condition is readily preventable by adequate cooking. The larvae are instantly killed at 60°C. It is safe to say, therefore, that pork which has lost its natural pink color and has turned gray or brown with cooking is safe to eat. Prevention should be directed at the domestic level of cooking. This is the only certain way of preventing human infestation.

Bacterial food poisoning: It is customary to subdivide bacterial food poisoinings into those which result from the ingestion of a preformed toxin and those which result from the multiplication of an organism in the food and in the host.

STAPHYLOCOCCAL FOOD POISONING

This is the commonest form of food poisoning in Canada today. The symptoms are produced by the ingestion of a heat-stable enterotoxin that is given off by certain strains of staphylococcus. The organism is introduced into food by handlers who harbor the particular type of staphylococcus in the nose or on the skin. Not infrequently a carrier will be found to have a nasal or aural discharge, a boil or acneiform lesion on the skin. The organism grows well at room temperature and is not inhibited by sugar or salt. It will thrive in precooked ham, cream-filled bakery goods, potato salad, and similar foods.

The symptoms are usually explosive in onset. They consist of diarrhea, vomitting, and prostration and develop in an average of six to nine hours after the ingestion of the toxin. The severity of the symptoms depends both upon the potency and the dosage of the enterotoxin consumed. Antibiotics have no place in the treatment of this type of food poisoning. The illness is produced by the toxin that has been preformed in the food. Once the intoxication has passed, the symptoms will cease since there is no further bacterial growth in the host.

The severity of the symptoms and the number of persons involved is directly proportional to the length of time that the food has been allowed to remain under conditions that have been favorable for bacterial multiplication. Oddy and Clegg[5] described a staphylococcal outbreak that occurred in a group of miners as a result of eating pressed beef sandwiches. The food had been prepared and distributed to the miners working on the afternoon and evening shifts of the same day as preparation had taken place, and to another group of miners working on the morning shift of the following day. In this latter group there were 167 cases of food poisoning. No one in the two earlier shifts became ill.

BOTULISM

This a rare and often fatal form of food poisoning that results from the ingestion of a heat labile toxin formed from the spores of the organism Clostridium *botulinum*. The majority of outbreaks in the United States[6] are related to the consumption of improperly processed, home-canned vegetable such as string beans or beet root. The symptoms usually develop within 24-48 hours. They are referrable to the nervous system and not to the gastrointestinal tract. Constipation is a very common symptom. Initially, there is difficulty in swallowing and blurring of vision due to paralysis of the muscles of deglutition and accommodation. The paralysis spreads rapidly to all parts of the body including the muscles of respiration. This disease is prevented by ensuring that all home-canned vegetables are recooked before eating to destroy any toxins that may be present.

SALMONELLA FOOD POISONING

This is the second most common form of food poisoning. About 600 types of this microorganism[8] have been identified. Food may be infected from its source, for example, poultry, meat, eggs, or the organism may be introduced into food by infected food handlers or rodents. The food stuffs through which infection is commonly transmitted, in order of frequency are: processed meat, cream-filled buns, ice cream, shellfish and tinned fish, eggs, milk, cheese, fruit and vegetables. Food will most likely be infected if it is:

1. contamined
2. stored at a temperature that favors bacterial multiplication
3. if it is bland that is, alkaline
4. if it is moist
5. if it is inadequately cooked.

Prevention, therefore, is directed to

all of these factors. The symptoms are usually diarrhea and a febrile general malaise. They develop within 6-24 hours and may last from 2-4 days. A symptomless carrier state will persist for several weeks after infection. The number of secondary cases that could develop as a result of this state can be largely prevented if there is strict adherence to toilet hygiene and hand washing.

CLOSTRIDIUM *WELCHII* FOOD POISONING

This is the third most common form of food poisoning.[7] It is only in recent years that bacteriologists have begun to look for this organism when investigating outbreaks of food poisoning or examining suspicious items of food. Meat is the usual vehicle. Infection develops when the spores of Clostridium *welchii* are able to germinate at room temperature after cooking. If cooked meat is refrigerated after use, the spores are not able to germinate and produce disease. The symptoms develop in 9-23 hours. They consist of stomach cramps and diarrhea. There is no fever and vomiting is rare. Fortunately the disease is universally mild. If these symptoms occur in an individual who has a history of having eaten boiled, stewed or, more rarely, roast meat, cooked some time in advance it should immediately suggest Clostridium *welchii* poisoning.

References

1. Summary of Disease Outbreaks. *Journal of Milk and Food Tech.,* Vol. 22 No. 11, November 1959.
2. Smith, M., Spalding, J. M. K. *Lancet,* Vol. 11, No. 7110, 1959.
3. Notifiable Diseases Summary, Dom. Bureau Stat., Canada. December, 1959.
4. Notif. Diseases Summary, Dom. Bureau Stat., Canada. April, 1960.
5. Oddy, J. G., Clegg, H. W. *B.M.J.* 1947.
6. Dack, G. M. *J.A.M.A.,* Vol. 172, No. 9.
7. Cl. *welchii* Food Poisons. *B.M.J.,* March, 1960.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — NOVEMBER, 1920)

When the nurse first appeared in our schools her function was thought to be mainly the detection of infectious disease. This, of course, still receives attention but we are striving to change the generally accepted assumption to the true idea that a school nurse means "health."

* * *

"As President, I would remind you that the magazine (*The Canadian Nurse*) is the property of the graduate nurses of Canada. What have you done to help and improve the magazine?

— EDITH MCPHERSON DICKSON

* * *

A course in public health nursing has been established at the University of British Columbia. This course is under the combined departments of nursing and public health connected with the University.

* * *

It is stated that a medical clinic for those who are well, is being established at London, Ont. It is proposed to have well people come to the clinic for examination, so that they may learn whether they are suffering from incipient disease, so as to secure treatment before it is too late.

* * *

The most important part of the nurse's education is her thorough instruction in practical methods. It is what she comes to a hospital to learn, and something she cannot get from books and lectures.

* * *

You are all aware of the difference between the old and new way of teaching nursing. In the old way the probationer was put at once in a ward to do as best she might the work of a junior nurse . . . In the new method the pupil is under an instructor chosen especially for her ability to teach . . . An objection to this (latter) method has been suggested, and that is the possibility of the patient being so much material for the benefit of the nurse, which attitude is far from the ideals of our profession.

Interviewing the Patient about Diets

BETTY THOMAS, B.SC. (H.EC.), R.D.

The services of dietitians in hospitals have been available to doctors for many years but their use in private medical practice is a relatively new trend. It is becoming increasingly popular in various medical units.

A CONSULTANT DIETITIAN is a member of the medical team who assists the doctor in translating his dietary prescription into foods and menus for the ambulant patient. The responsibility for teaching a diet to a patient is assumed by the dietitian and thus saves the doctor much valuable time. Specific diets should not be referred to as "special" diets. They are simply variations of a normal diet for a special reason. They are therapeutic in that the right combination of foods produces a therapeutic effect. An intelligent approach to the diet by both the patient and the dietitian will help achieve this value. This involves education of the patient, correction of food habits and fallacies about food and gentle persuasion to accept the doctor's advice regarding the diet. Since food is such a universal subject, most people feel they are authorities on it. It is sometimes difficult to convince a person that he can or should change his present eating habits.

My work has to do mostly with therapeutic diets and general dietary instruction, if necessary. The Winnipeg Clinic is a private medical clinic staffed, at present, by 55 medical specialists and 174 non-medical personnel. The non-medical staff includes registered nurses, practical nurses, x-ray and laboratory technicians, pharmacists, physiotherapists, medical secretaries, a librarian and a dietitian. The function of the dietitian is to teach the diet prescribed by the doctor.

Diets Under Medical Supervision

The patient is seen by the dietitian after his medical investigation has been completed and only if the doctor requests that the dietitian instructs him in a particular diet. No one is given a diet unless it is ordered by a doctor. Each patient is seen individually. The interview lasts from 15 to 45 minutes, depending on the type of diet and also, to some extent, on the understanding of the patient. Copies of the basic diets are kept in readiness to avoid any unnecessary waiting. Any changes required are made on the spot to suit the individual patient.

Before a patient arrives for his diet instruction, it is necessary to know a few facts about him. A quick glance at his medical history will give an overall picture of the person to whom you will be talking. Such information as occupation, age, living accommodation, language difficulty and diagnosis are important in explaining a diet. Acceptance of a diet varies greatly. Basically, no one likes to be told what he can eat. One common reaction to the doctor's decision to place his patient on a diet is that the patient feels that he will starve to death regardless of the type of diet that he is to have. A friendly smile and a cheery word as you greet the patient will help to dispel any developing hostility, although some people remain resentful throughout the interview.

Initial Approach

The first step in the interview is to find out if the patient fully understands why the doctor wants him to have the diet. He will have been told this already but if the dietitian can reiterate the reason, the patient feels that there is indeed teamwork involved in his medical management. The reason for the diet is repeated briefly, bringing his particular condition into the explanation. The patient is then asked what he has been eating. This varies from just about everything to being afraid to eat anything at all. This part of the interview is very time-consuming but it gives a very good picture of what improvements can be suggested.

The diet itself is thoroughly ex-

Miss Thomas is consultant dietitian at the Winnipeg Clinic, Man.

plained and reasons given why certain foods are omitted. A complete understanding is not expected at this time but with the explanation in his mind, it is hoped that when the patient reads the diet again at home, it will become clear. For this reason, as much information as possible is given in printed form without being so voluminous that it discourages the amount of reading necessary. The diets include menus, recipes, calorie charts, lunch suggestions, seasoning suggestions, etc. Ways and means are discussed for adjusting the diet to the family's meals, packing lunches, travelling and managing meals when invited out. These situations can be solved without too much difficulty and without being obvious. The patient is encouraged to return or to telephone for any further information that he wishes. It should be made very clear that, for the best results, the diet must be followed carefully. On the other hand, the patient should not be made to feel enslaved by it. In most cases, the diet is a temporary one. If he knows that there is an end in sight, he will be more likely to follow the instructions for the time required.

The Immigrant Patient

Among the problems encountered in interviewing a patient, the language barrier is the most difficult with which to deal. If a patient does not speak English, he usually comes in with a friend who does. The diet is explained to the friend who, in turn, translates it to the patient. This is not always satisfactory since you are not entirely sure that the patient understands and also, the friend is unable to answer any questions that may arise later on. The Clinic employs an interpreter and, although this is still a three-way conversation, a more satisfactory explanation can be given.

With the increasing number of immigrants coming to Canada now, language has become less of a problem than the "home-land" customs that are becoming quite a consideration in planning diets. These people are reluctant to change their long-standing food habits, and indeed, seldom do. In some cases, our Canadian food does not agree with them. For the most part they find it too sweet and starchy. Even our bread tastes sweet to them. A happy medium between our food and theirs is the aim. Religious customs are taken into consideration too, and wherever possible they are respected. The one exception is with the severe diabetic in which case the dietary control must be meticulous.

Food Faddist

One of the most difficult persons to reason with is the food faddist. He has such hard and fast ideas about what he should be eating that no one can change his theories. In some cases, it is the very food fad that he has been following that has made medical aid necessary. With such extensive advertising these days, susceptible persons are quickly convinced by fantastic claims concerning food as well as other products. They tend to rush out and buy a supply of the particular item. There are hundreds of food fallacies on record such as "rice, plus a regular diet, cures high blood pressure," "lemon juice is a cure for arthritis," "if a certain nutrient is good for you, then more of it is better." These and many other similar ideas are denounced as untrue but the patient may refuse to accept the denunciation. The fact that such practices could be a hazard to their health is unbelievable to them. A general discussion on healthful eating habits is required, using Canada's Food Rules as the basis.

Obesity

Since obesity is Canada's number one nutritional health problem today, the majority of patients coming for diets are those who are overweight. They form an interesting group. They have various ideas about reducing, most of which are either erroneous or not practised, as witnessed by their continuing overweight state. The women far outnumber the men in this group. The need for reducing is more often therapeutic than cosmetic. Nearly all overweight people firmly believe that they do *not* overeat and that a diet will never work. These patients have a long list of excuses on which they fall back to avoid having to change their present food patterns. Probably the one used the most often is "my whole family is fat, it's hereditary." Another is "I digest everything so well that all the food I eat turns to fat," and "I eat like a bird." The last one is true, however. Birds eat all day long! Many overweight patients have, at one time or another, tried a fad diet such as the "banana diet," "the egg diet," "the blitz diet," and liquid diets. They come to us still looking for a quick and easy way to shed their excess poundage. It is pointed out at the beginning of the interview that *there is no quick way to lose weight*. It is a long-term program and nothing but harm can be expected from a fad diet.

The approach to a reducing diet is the same as with all diets. Show the patient *why* he must lose weight: to relieve a backache, to lower blood pressure, to take the strain off such organs as his heart, to say nothing of his feet! Patients seldom connect overweight with their aches and pains. You try to convince him that it will not be nearly as hard as his friends tell him. Often, he will be learning to eat differently and not necessarily less.

The diets are designed to suit individual needs and occupations. They include one for people who have to travel extensively. When a suitable diet has been selected, it is explained word for word and, again, reasons are given why certain foods should be avoided. The distribution of the food is stressed. This is something which rarely occurs to a patient as being a factor in reducing. If a man dashes off to work with no breakfast and a sandwich for lunch, he will end up by overeating at his evening meal. Then he wonders why he isn't losing weight! The advent of television has contributed to the overweight condition of many people. This is discussed in relation to the reducing program. Patients are encouraged to correct bad food habits and errors in cooking. They are encouraged to come back and weight in at any time. Those who lose weight are only too pleased to come back and show off; those who don't, are not so eager!

Patent reducing plans are discouraged. They are not only expensive but they are also not suitable for a long-range program. Often the only thing that is reduced is the bank balance. Children are treated for obesity in much the same way as adults. The mother receives instruction in helping the child through avoiding forbidden foods and substituting low calorie foods for higher ones. Children have proven to be more conscientious than adults in following reducing programs if the mother cooperates well.

The Diabetic Patient

Time and patience are required in teaching a new diabetic patient. The diet is usually unlike any that he has ever encountered before. If the explanation is too technical, he will feel defeated before he even starts. The most common reaction of the patient when he is told that he has diabetes is, "How could this happen to me, I don't take sugar?" This and other myths about the cause of diabetes are quickly discounted. He has to be reassured that it is not what he has been eating that has caused the condition. The first interview is as simple as possible. The patient is told to try out the diet for a few days and then to return or to telephone in order to have any questions answered. There are usually many questions that have developed as he became familiar with the diet. A second interview is sometimes more valuable. The patient is over the initial shock of hearing that he has diabetes. He has begun to accept his condition. He will be more receptive, cooperative and anxious to know if he is following the diet correctly.

The Ulcer Patient

While some patients resent a diet, others are most grateful. Among the latter are the ulcer sufferers. They are delighted to learn what they can eat without running into trouble. These patients will know about some of the foods that have upset them but not about all of the ones that might have a similar effect. It is sometimes surprising to find out that their favorite food could be at fault.

Acne

Patients with acne make up a large number of the patients treated by diet. They are often adolescents who are very self-conscious about their condition and eager to learn what they should be eating. The present vogue of soft drinks, "chips," hot dogs and hamburgers is most damaging to these youngsters and it appears, sometimes, that they eat nothing else. An acne diet is a simple well-balanced diet with emphasis on avoiding excessive fat.

Helpful Ideas

Occasionally a patient will turn up a new idea or a recipe that might be used for other patients. These are discussed and in most cases are accepted. An example of this is the gluten-free bread that must be used on a gluten-free diet. We have tried many recipes for this bread and had equally as many complaints about it. One day a patient came in with a recipe with which she had experimented and with a sample of the gluten-free bread. We found it much improved over any that we tasted previously. Her recipe was included in the diet. Patients on these unique diets sometimes feel a responsibility to do this experimenting so that others may benefit from their experiences. This is true in the case of allergy diets. Several of our recipes have come from patients who have had to omit certain foods and have found a suitable substitute. All suggestions from patients are welcomed and used whenever possible.

Teaching a person to change his way of eating is not just a matter of *telling*, but rather of *selling* the idea as well. Eating should be a pleasure and at the same time contribute to good health.

In Memoriam

Kate Maude Beckett, who graduated from Toronto Western Hospital in 1912, died in Toronto on August 3, 1960.

* * *

Emilia Ansa Bergman, who graduated from Regina General Hospital in 1932, died in Toronto on August 13, 1960. She had engaged in private nursing.

* * *

Simonne Biron, a senior student in the school of nursing of Notre Dame Hospital, Montreal, died on August 16, 1960, from injuries received in an automobile accident.

* * *

Annie Arnold Bishop, who graduated from Grace Hospital, St. John's, Nfld. in 1932, died there on July 11, 1960. Miss Bishop was in charge of the student health program at Grace Hospital for some time. She had been active in the committee work of the A.R.N.N. and was membership convener of the St. John's Chapter.

* * *

Helen Curliss, who graduated from Toronto General Hospital in 1934, died suddenly on July 16, 1960. On the staff of New Mount Sinai Hospital, Toronto, at the time of her death, Miss Curliss had worked at the Sunnybrook D.V.A. Hospital for many years.

* * *

Pearl Caldwell Graham, who graduated from Ontario Hospital, Whitby in 1932, died at Barrie, Ont., on July 18, 1960. Prior to her retirement in 1959, Miss Graham was director of nursing at Ontario Hospital, New Toronto. She had served with the Ontario Department of Health for 27 years.

* * *

Dorothy (Boyce) Donaldson, who graduated from Victoria Public Hospital, Fredericton, N.B. in 1941, died in July, 1960 at Roblin, Man. Mrs. Donaldson served with the RCAMC during World War II.

* * *

Agnes Margaret Hart, who graduated from Moose Jaw Union Hospital in 1930, died on June 27, 1960. A member of the staff of the Saskatoon Tuberculosis Sanatorium, ill health had forced Miss Hart to retire earlier this year.

* * *

Dorothy Holmberg, a graduate of Royal Jubilee Hospital, Victoria in 1945, died in Denver, Colorado on June 22, 1960. She was studying at the University of Colorado at the time of her death.

* * *

Isabelle Frances (Carey) Irwin, who graduated from Toronto East General Hospital in 1936, died in Toronto on August 23, 1960.

* * *

Hazel M. (Wilson) MacIver, who graduated from Ontario Hospital, New Toronto in 1931, died in Toronto on June 20, 1960.

* * *

Loretta McGuire, who graduated from Lorrain School of Nursing, General Hospital, Pembroke, Ont. in 1927, died in Hampstead, N.Y. on August 5, 1960. She had engaged in private nursing.

What is the Sodium Restricted Diet?

Vivian M. Bruce *and* Elizabeth Feniak

With improvement in the analytical methods for the determination of sodium in foods and other biological constituents, the sodium restricted diet has gained new prominence.

Sodium is an electrolyte represented by the symbol Na. It occurs in plant and animal organisms as the ion Na+. Sodium complexes in living matter are unknown[4]. Restriction of sodium chloride or table salt is associated with the sodium restricted diet. Perhaps for this reason, the sodium restricted diet has been described by such terms as "salt free," "salt poor," "low salt." These terms are non-specific and confusing. They should be avoided. When a sodium restricted diet is indicated, it is not *salt* that is the factor to be restricted, but *sodium*. It is possible with the present average analytical tables to calculate the sodium content of the daily diet in milligrams.

Sodium functions in the body in the following ways[5]:

1. In maintaining osmotic pressure between the solutes of the extra-cellular fluid and the solutes within the cells.
2. As a buffer in conjunction with carbonate and phosphate, thus helping to maintain the pH of the blood within normal limits.
3. In the conduction of nervous impulses and muscle contractility.
4. In maintaining water balance of the body.

Water is retained or excreted with sodium in quantities to maintain the tonicity of body fluids.

Normal Sodium Requirement

How much sodium can be considered to be a normal requirement? An optimum level of sodium chloride in the adult human has not been established. The daily average intake estimated by the National Research Council is 7-15 grams (or 7,000-15,000 milligrams)[5]. Dahl reported that the effect of an excessive intake of sodium chloride resulted in hypertension[3]. He observed that primitive tribes had a low incidence of hypertension. Other evidence was obtained from animal experiments; from the relief of hypertension by salt restriction; from the incidence of hypertension among individuals on high salt diets. Over a period of 10 years, Dahl studied 75 essential hypertensive persons, normal persons, and persons with unrelated diseases. The diet given contained 100-150 mg. of sodium plus 4 grams of sodium in the form of pills. When the pills were removed from the diet, ¼ to ⅓ of the persons experienced a fall in blood pressure. Dahl recommended that the salt intake for persons with existing hypertension should be below 1-2 grams while the intake for non-hypertensive persons could be 5 grams.

Studies were carried out with rats to assess the chronic toxicity of sodium chloride. Ball and Meneely[1] maintained 546 male Sprague-Dawley rats and 21 female rats of the same strain on 10 levels of added dietary sodium that ranged from .15-21 per cent sodium chloride beginning at 5 weeks of age and continuing throughout their lifetime. Control rats were fed a diet that contained 5.6 per cent sodium chloride. After 19 months on the diet, 80 per cent of the rats that had been fed 9.8 per cent sodium chloride developed hypertension. After 15 months on the diet containing 14.0 per cent sodium chloride, all of the rats in this group were dead. Similar results were observed when a group of rats was fed diets containing 21.0 per cent sodium chloride for 9 months. Results of animal experimentation cannot be directly applied to human nutrition. However, observations of abnormal and disease states may contribute information that can be used in the determination of a recommended

---

Miss Bruce is the graduate assistant and Miss Feniak is associate professor in foods and nutrition at the University of Manitoba.

optimum sodium chloride intake for the adult human.

The principal loss of sodium occurs through the urine, skin and feces. The normal kidney conserves sodium. Approximately 6.0 per cent of the filtered sodium is excreted. The tubules of the kidney reabsorb the remainder of the sodium[6]. The tubular resorption is modified by the action of the adrenal cortical hormone. Dahl[2] reported that during a 10-year period, ambulatory patients with essential hypertension who received 100-200 mg. sodium daily did not require sodium supplements.

Ingestion of Sodium

Sodium may be ingested through foods, water and medicines. Raw and processed foods have been analyzed for sodium. Sodium is added to a number of foods during processing. Considerable work remains to be done on the sodium content of foods. Sodium values for foods may vary with differences in variety, climate and soil.

In general, foods from animal sources are high in sodium. Meats, particularly organ meats, shellfish, eggs, milk and cheese contribute large amounts of sodium. Some vegetables such as carrots, celery, spinach, beet greens contain appreciable amounts. The relative sodium values of these foods, unsalted, are approximately as follows:

	approximate value milligrams
meat, 1 oz.	25
milk, 1 8-oz. cup	120
egg, 1	70
bread, unsalted, 1 oz. slice	9
butter, unsalted, 1 tsp.	1

Recently the sodium content of fish flesh has been studied by Thurston and Osterhaug[7]. They studied the effects of handling on the sodium content. Only when sodium compounds were added did the sodium content of the fish flesh change. One of the processes studied was the dipping of fish fillets in water to provide a protective icy glaze. When fresh water was used, there was no appreciable change in the sodium content. Information about the changes in the sodium content of foods during cooking is far from complete. Thurston and Osterhaug reported that there was no change in the amount of sodium during the baking of fish.

Sodium compounds that are added to foods will be designated on the food labels. The importance of reading food labels cannot be overemphasized in regard to the sodium restricted diet. Some of the sodium compounds found most frequently in processed foods are:

1. Salt (sodium chloride)
2. Baking powder (sodium carbonate) — used to leaven quick breads and cakes
3. Baking soda (sodium bicarbonate) — used to leaven breads and cakes
4. Brine (table salt and water) — used in the processing of food to inhibit growth of bacteria
5. Disodium phophate — used in some quick cooking cereals and processed cheeses
6. Monosodium glutamate — used to enhance food flavor; obtainable under various trade names
7. Sodium alginate — used in many chocolate milks and ice creams for smooth texture
8. Sodium hydroxide — used in softening and loosening skins of certain fruits and vegetables during processing
9. Sodium benzoate — used as a preservative
10. Sodium propionate — used to inhibit the growth of molds in breads and cakes
11. Sodium sulfite — used to bleach certain fruits to which an artificial color is to be added; may be used as a preservative for some dried fruits.

Drinking waters may constitute a source of sodium. Sodium values can usually be obtained from the local health department. If the sodium level is such that appreciable amounts of sodium are being consumed, distilled water should be used for drinking and cooking. Water that has been "softened" can be suspected of containing increased amounts of sodium.

Certain types of medicines contain sodium: laxatives, pain relievers, cough medicines. These should not be used indiscriminately. The labels on tooth pastes, tooth powders and mouth washes should be carefully checked since they may contain sodium compounds.

Preparation of Low Sodium Diet

The restriction of sodium generally indicates the preparation of food without salt. Preparation of food should be relatively simple. Recipes containing significant amounts of high sodium foods, such as milk and eggs, should be avoided. Milk, a high sodium food, should be included in all low sodium diets in amounts varying with the degree of sodium restriction. On very low sodium restrictions, it may be necessary to curtail the amount of milk, or to substitute a dialyzed milk — one which has had the sodium ions removed.

On the extremely restricted sodium diet, careful planning is necessary in order to prevent deficiencies of other essential nutrients. Because of the restriction of meat and milk, protein, riboflavin and calcium are the nutrients most likely to be affected. Prolonged elimination of salt may mean reduced iodine intake. Other sources of this mineral must be provided.

The sodium restricted diet is lacking in the flavor normally contributed by the addition of table salt. It tends to be tasteless and unappetizing to the patient and, as a result, it is important to make use of other seasonings. The following common flavorings do not contribute significant amounts of sodium to the diet[5]:

allspice
almond extract
cocoa
curry
garlic
mint
mustard, dry
nutmeg
basil
bay leaf
caraway
cinnamon
cloves
ginger
lemon juice
maple extract
marjoram
oregano
paprika
peppermint extract
sage

There have been many types of salt substitutes devised. However, these should be used only on the advice of a physician, since the ion substituted for sodium (usually potassium or ammonium) may be physiologically unsuited to the patient.

References

1. Ball, C.O.T., Meneely, R. Observations on Dietary Sodium Chloride, *J. Am. Dietetic Assoc.* 33:366, 1957.

2. Dahl, K., Role of Dietary Sodium in Essential Hypertension. *J. Am. Dietetic Assoc.* 34:585, 1958.

3. Dahl, K., Salt Intake and Salt Need. *New Eng. J. Med.* 128:1205, 1958.

4. Harowitz, F. *Biochemistry: An Introductory Textbook.* New York: John Wiley and Sons Inc., 1955.

5. National Research Council. *Sodium Restricted Diets. The Rationale, Complications and Practical Aspects of their Use.* Publication 325. Division of Biology and Agriculture, Washington, D.C., 1954.

6. Thompson, R.H.S., King, E. J. *Biochemical Disorders in Human Disease.* New York: Academic Press Inc., 1957.

7. Thurston, E., Osterhaug, L. Sodium Content of Fish Flesh. *J. Am. Dietetic Assoc.* 36:212, 1960.

Thirty-eight patients from the gastroenterology ward of Wadsworth Veteran's Hospital were used to determine gastrointestinal blood loss during ingestion of aspirin. Their erythrocytes were tagged with Cr^{51}, enabling a quantitative measurement of blood present in the feces. Before administration of the aspirin all were losing less than 2 ml. of blood per day in the feces. After administration fecal blood loss rose in every subject. The increases ranged from 0.2 to 13.5 ml. per day and averaged 3.3 ml. per day.

The patients' gastrointestinal history, the type of aspirin, (tablet or alkaline solution), did not affect the outcome. Blood loss was less when antacids were administered with the aspirin.

— *Abbott Abstracts*

Now, for the first time, a new booklet about menstruation answers actual questions that have been asked by thousands of girls all over the country. Called "Accent on You," this booklet tells girls what they want to know about every phase of the menstrual process, and shows in simple, labeled diagrams how and why the cycle takes place. Its 24 pages of facts and pictures also cover questions about activities, exercise and dating and personal care. Available free of charge "Accent on You," is written specifically to help maturing girls understand that menstruation is natural, normal and merely a part of healthy womanhood. Mothers will find it helpful in explaining menstruation to their daughters. Address your request to Department CN — 360, Canadian Tampax Corporation Ltd., Brampton, Ontario.

Adult Requirement for Calcium

ELIZABETH FENIAK

How much calcium do adults require compared to children?

Functions

CALCIUM IS THE MINERAL element that is found in largest quantities in the human body. Approximately 1.5 per cent of body weight is calcium, e.g., 2 pounds in a 125-pound woman. Approximately 99 per cent of it is in combination with phosphorus in the bones and teeth. The balance exists in a fairly constant concentration in blood serum, partly in bound form with protein and partly in ionized form. The bone calcium functions to give strength and rigidity while calcium of the blood serum functions in the clotting of blood, maintenance of muscle tonus, cell permeability and nerve transmission$_9$.

Metabolism

Studies with radioactive calcium have contributed greatly to our knowledge of the metabolism of this mineral. Absorption occurs in the small intestine from which the mineral is carried in soluble form by the blood to all parts of the body. The calcium of the lattice-like trabeculae of the ends of the bones is the most readily available source of the mineral, although even the constituents of solid bone are in a state of dynamic equilibrium with constituents of the blood. Through regulation by the parathyroid gland, this reserve may be used to maintain a constant blood level.

Many studies on calcium absorption indicate a fairly limited and variable absorption of the mineral, with values usually occurring between 20 and 30 per cent and frequently lower. Absorbed calcium is excreted partly as soluble salts in the urine, partly in the feces. Fecal calcium also includes ingested calcium that was not absorbed.

One of the factors that influences the amount of ingested calcium that will be absorbed is the degree of acidity in the upper intestinal tract. The presence of oxalic and phytic acid in a food renders the calcium content of that food unavailable because of the resultant formation of insoluble calcium salts. Vitamin D is closely related to calcium and phosphorus metabolism and calcium absorption is improved when vitamin D intake is adequate. It has been shown also that an individual's established level of calcium intake affects utilization, a higher retention of the mineral being found in those accustomed to a very low calcium intake.

Requirements

Because of individual variation in absorption, and difficulties in the interpretation of data from balance studies, the establishment of a recommended level of calcium intake in adults has been difficult. For growing children, it has been possible to estimate weight gains due to bone growth and, with due consideration to percentage retention of the mineral, calculate the amount of dietary calcium necessary to take care of this demand. For adult needs, the balance technique has been the basis for establishing minimum requirements. This method compares excretion levels with intake. A positive balance, in which intake exceeds excretion, indicates storage of calcium and is normal in growing children, and pregnant and lactating women. A negative balance would be indicative of faulty metabolism with loss of bone stores of calcium. The healthy adult should be in balance with enough calcium being absorbed from food to meet daily losses of the mineral.

The minimum level of intake at which a positive balance occurs has been used as an estimate of the adult minimal calcium need. Sherman suggested 0.45 grams on the basis of early studies. Steggerda and Mitchell recommended 10 milligrams per kilogram of body weight (or 0.7 grams for

---

Miss Feniak is associate professor in Foods and Nutrition at the University of Manitoba, Winnipeg.

a 70 kilogram man). The dietary standards established for use in Canada and the United States have recommended calcium intake levels in line with these findings. The Canadian standard[1] designed to represent a minimal nutrient intake compatible with health, expresses calcium requirement as proportional to body size (0.55 grams for a 120-pound woman, 0.75 grams for a 160-pound man). The Recommended Allowances of the U.S. Food and Nutrition Board, that are intended to allow a "margin of sufficiency" above minimal requirements[4] so that all variations of requirement among the population at large may be covered, affirms its previously established allowance of 0.8 grams of calcium per day for adults (exclusive of pregnant and lactating women).[6] For the second half of pregnancy and during lactation, the Canadian Standard recommends the addition of 1 gm. above maintenance figures, the U.S. standard a total of 1.5 grams and 2.0 grams for the respective periods.

Dietary standards are estimates of the requirements of *average* healthy individuals and are designed to be used as a reference against which to assess the nutritional status of population groups or the food supply of an area. It is incorrect to use them as a rigid definition of the needs of any single individual, without due consideration of the wide range of individual variation that exists around any average figure.

Calcium Equilibrium on Low Intake

The figures used as standards in the U.S. and Canada are considerably above the intake of persons living in numerous underdeveloped areas of the world where milk supply is extremely low. Balance studies with these subjects give valuable information about minimal calcium for adult maintenance. Many such investigations report that individuals are maintaining calcium equilibrium on extremely low intake.

Ceylonese boys were found to be in positive balance on an intake of only 0.2 grams per day, absorbing and retaining from 34 to 89 per cent of the calcium in the food intake[7]. Ten Peruvian males, of normal stature and apparently healthy, who had been living on diets low in calcium for long periods of time, were found to maintain equilibrium on an average daily requirement of 0.1 to 0.2 grams. Their percentage ranged from 6 to 30 per cent. That the retention was not unusually high was taken as partial evidence that the men were not in great need of extra calcium[2].

Hegsted criticizes the use of the balance technique as a means of establishing a recommended level of intake[3]. The effect of the previous diet of the subject appears to relate very closely to the level at which calcium equilibrium is achieved. The more efficient utilization of a meagre calcium intake is referred to by many workers as evidence of physiological adaptation to a state of undernutrition. Adaptation to a low calcium intake however, appears to take a long period of time for persons accustomed to a high calcium diet.

Most of 26 Norwegian men, studied over a four-year period on an intake of 0.45 grams of calcium per day, were able to achieve calcium balance on this intake after a period of time. This was not true of all the subjects however. Calcium retention did not seem to relate to body size or age; in two cases, emotional factors appeared to affect calcium balance[5].

Several decades ago, it was a widely held belief that a high intake of calcium throughout life would improve health and vitality in adult life. This idea was encouraged by Dr. Sherman's early work with rats. Increased longevity and improved reproductive ability were claimed as a result of increased calcium intake. However, differences in calcium utilization between rats and humans made the interpretation of these results in terms of human adult needs somewhat uncertain.

Many workers argue that there is no real evidence of calcium deficiency in those areas of the world where the food supply provides very limited amounts of the mineral. There is also little conclusive evidence of the advantages or disadvantages of excessive calcium intake. Bone calcium reserves might be expected to provide advantages to women during child-bearing years. Adult osteomalacia, linked with pregnancy and lactation in certain Far Eastern countries, is said to respond to vitamin D rather than to calcium therapy[9]. Osteoporosis, as it occurs in the aged, is generally attributed to faulty bone metabolism rather than to dietary calcium deficiency. After examination of research findings to date, the U.S. Food and Nutrition Board concludes that "adaptation to wide ranges of calcium intake is possible without manifestation of observable effects" and that "ingestion of excessive calcium in foods has not been shown to be, nor is seriously considered to be, harmful."

In a *Suggested Guide to Interpretation of Nutrient Intake Data*[4], the Interdepartmental Committee on Nutrition for National Defence (U.S.) suggests the following rating of calcium intake in grams per day, in terms of a 25-year-old, 65 kilogram (143 lb.) male:

Below 0.3 — deficient
0.30 to 0.39 — low
0.40 to 0.8 — acceptable
Above 0.8 — high

This rating considers a fairly broad range of intake as acceptable and acknowledges the difficulty of setting a more precise yardstick for recommended adult intake on the basis of available evidence.

Conclusion

Many dietary surveys in Canada and the U.S. report a lower consumption of calcium than the recommended standards. This is particularly true of adolescents and pregnant women whose high needs are undisputed. The estimated average supply of calcium in food apparently consumed by Canadians per person per day in 1956 was 1.057 grams[8]. This figure applies to food distributed at the retail level, but makes no allowance for wastage in stores and households or losses in cooking. Calcium is not widely dispersed in foods. Eighty per cent of the total calcium intake comes from dairy products, i.e., milk and cheese. Very small amounts are contributed by dried fruits, green leafy vegetables and legumes. Somewhat larger amounts are available in salmon, including bones, and sardines, and the leaves of broccoli. A diet in which milk and cheese are lacking or are in low supply, is very unlikely to contain even maintenance adult requirement for this mineral.

References

1. Canadian Council on Nutrition. Canadian Dietary Standard. Canadian Bulletin on Nutrition, Vol. 2: No. 1, 1950.
2. Hegsted, D. M., Moscoso, I. and Collazos, C.: A study of the Minimum Calcium Requirements of Adult Men, *Journal of Nutrition,* Vol. 46: 181, 1952.
3. Hegsted, D. M.: Calcium Requirements, *Nutrition Review,* Vol. 15: 257, 1957.
4. Interdepartmental Committee on Nutrition for National Defence. *Manual for Nutrition Surveys,* Washington, 1957.
5. Malm, O. J.: *Calcium and Adaptation in Adult Men,* Oslo University Press, 1958. (Abstracted in the Journal of the American Dietetic Association, 36:26, 1960.)
6. National Research Council, *Recommended Dietary Allowances Revised 1958,* Pub. 589, National Academy of Sciences, Washington, D.C., 1958.
7. Nicholls, L. and Nimalasuriya, A.: Adaptation to a Low Calcium Intake in Reference to the Calcium Requirements of a Tropical Population, *Journal of Nutrition,* 18: 563, 1939.
8. Nutrition Division, *Canadian Food and Nutrition Statistics 1935 to 1956.* Queen's Printer, Ottawa, 1959.
9. Wohl, M. G. and Goodhard, R. S. (ed.): *Modern Nutrition in Health and Disease,* Philadelphia, Lea and Febiger, 1955.

The mothers of Norfolk believe that there is no better place than home in which to have a baby. Above 60 per cent of them are delivered at home. In no other country is there such a large proportion of deliveries at home; also there was only one death in Norfolk in 1958 which was due to pregnancy, delivery or abortion.

— Nursing Times, April, 1960

Paint the bottoms of metal cans such as contain baking powder etc., with nail polish to prevent rusting.

— *Alumnae News,* Hotel Dieu of St. Joseph, Windsor.

* * *

All men have a reason, but not all men can give a reason. — CARDINAL NEWMAN

A CAPRICIOUS APPETITE

MARY GOODFELLOW GROOME

How can nurses in the community help mothers solve difficult infant feeding problems?

IT WAS THE SORT OF sunny spring day that finds one out in the garden looking for the first sign of new life. On this particular day, however, excitement came unexpectedly from another quarter. A great moving van was drawn up at the bungalow next door and, amid the bustle of activity, I caught my first glimpse of my new neighbor. Little did I realize at the time that for many weeks there would be only very occasional glimpses!

It was not long before we became acquainted with Mr. and Mrs. Apostolidis, their busy four-year-old John and eleven-month-old Peter. John amazed us by his ability to slip from English to French to Turkish or Greek, all in the course of a single conversation. This, we learned, was because Mr. Apostolidis, a construction engineer, was Greek and his wife, a former school teacher, was Turkish. Both were also fluent in English and French so John was having a wonderful time growing up with a good vocabulary in all four languages.

In every conversation, Mrs. Apostolidis made reference to the baby's "capricious appetite." One evening, when Mr. Apostolidis and my husband were chatting on the patio, I invited him to bring his wife over for coffee with us. He replied that they could not go visiting together until the baby was older, as each feeding required about two hours. This, with her other housework, left his wife with very little time for any social life.

Meanwhile, John was finding it difficult to settle into his new surroundings. In order to attract attention, he became a local "Dennis the Menace." To enable Mrs. Apostolidis to keep an eye on him, he was recruited to amuse the baby during mealtime. It was soon after this that he was found watering the baby with the garden hose!

Peter's feeding problems thus influenced the life of the entire family and, to some extent, reached out into the community. He never experienced the satisfaction of a good meal, and very often suffered the wrath of his older brother. He had not learned to feed himself; had no variety in diet, and had the uncomfortable feeling of attention wrongly acquired.

The extra work involved left the mother tired and listless by the end of the day. Thus, the parents were deprived of each other's company and missed the opportunity to mix with other adults. The community lost the opportunity of learning about other countries, sharing new ideas. We also had to bear the brunt of the four-year-old's frustrations. Not only was John no longer the center of attraction in the home, he actually received very little attention of any kind. He had to fend for himself in a strange environment, without the support that a mother can give a small boy by just being on hand. His rebellion and subsequent punishment only led to greater rebellion.

Peter's Problems

I was curious about Peter and his eating habits. One day the opportunity presented itself, and I asked Mrs. Apostolidis about him.

Peter was born in Canada. He was bottle fed. His mother learned that solid foods were started very early in Canada so she followed instructions and started giving him cereal when the baby was ten weeks old. Peter objected from the beginning. Although he had taken the bottle well, he was not interested in solids. Mrs. Apostolidis soon found herself offering him something to eat whenever he was awake. Peter responded to this by turning

---

Mrs. Groome, a graduate of Montreal General Hospital, assists a prominent Montreal pediatrician in the program of teaching parents — mainly the mothers — how to care for their infants and children.

away from the spoon and ultimately, making a struggle before accepting even the bottle.

By the age of seven months, he had developed what his mother termed a "capricious appetite." I asked her what she meant by this. She explained by saying that Peter would eat well when he was hungry. He always accepted breakfast readily — cereal, an egg, and eight ounces of milk. (I can almost imagine him thinking, "No sense fussing right now. I'm too darned hungry!")

At nine months of age, Peter "caught a cold," had a low fever for two weeks, loose bowel movements, lost weight, refused all solids and, finally, after refusing liquids, was hospitalized.

Urinalysis indicated the presence of pus. With adequate treatment, he improved rapidly. Soon he took liquids but continued to refuse solids.

After telling the nurses about his prolonged mealtimes, the games to distract him, and the preparation of his favorite food, the mother offered to go to the hospital to feed him. This assistance was refused. Actually, while visiting him she noticed that his meals were usually finished in 20-30 minutes, and also that a variety of foods was taken. During the last few days in hospital Peter even took solids well.

In view of Peter's current behavior, I asked Mrs. Apostolidis what had happened when he was taken home. She smiled and replied that he must have been very hungry because for the next two or three weeks he ate almost every food that was offered without any fuss. Later, as he was coaxed to take more and to eat more often, his capricious appetite returned. At present the day seems to be one continuous mealtime!

Feeding Infants

This pediatric problem of faulty eating habits is a common one. It is one of the early attention-getting techniques used by a baby. It is one of the most difficult problems young parents have to solve. There are three main reasons for this:

Lack of systematic preparatory child care education for all adults.

Pressure of constantly changing trends in present-day child care methods. Differences in these trends are amplified by cultural, language and religious backgrounds.

The apparent lack of time available to the pediatrician to explain satisfactory procedures, even though the time this would take would be much shorter than that needed to correct the problem once it has occurred.

Feeding schedules provide only the framework within which the individual child's nutrition is planned. Time must be taken to explain the schedule to the parents; how it may be varied; how the child may react; how the parents should react. In short, parents should be warned to anticipate feeding problems, to recognize danger signals. They need to be equipped with the necessary knowledge to combat a problem at its inception.

The opportunity to effect a permanent improvement in Peter's eating habits was missed following his stay in hospital, primarily because, during that time, the acute illness and its treatment overshadowed the (then) lesser problem. Secondly, under pressure of a busy routine, the nurses overlooked two of the basic tenets of our profession: in order to give total care, we must know our patient; each procedure must be explained to and understood by the patient. In the case of a small child, we must know and give the explanations to the parents.

We note that while in hospital Peter's mealtime was limited to 20-30 minutes; his favorite foods were not always served; he had to accustom himself to a variety of new foods; there were no mealtime games, and no between-meal feedings. Given a detailed explanation at this time, Peter's mother could have continued the routine at home, and thus avoided what ultimately developed into a major problem.

It was at this stage that we met Mr. and Mrs. Apostolidis. They were pleased to find someone interested in Peter, and in them. After one or two conversations, the mother was asked to recall the five main points she had noticed at the hospital: shorter meal time; no mealtime games; variety of foods; no between-meal snacks; and meals served at a regular time, in a very matter-of-fact way. Their attention was then drawn to the results that had been obtained by this regime — a hungry Peter enthusiastically eating his meals. We discussed the reasons for the hospital routine and the results. Mr. Apostolidis was the first to agree that when Peter came home from the hospital his eating habits were much improved, and were preferable to the present ones.

It was pointed out that the present problem would not be resolved quickly. It was suggested that the first step should be a thorough examination by Peter's pediatrician. This examination assured the parents that Peter's health and physical development were normal, and that they could confidently embark upon a feeding routine similar to that used in the hospital.

As soon as the parents understood the reasons for the hospital routine, and Mrs. Apostolidis knew what Peter's requirements were and what he could manage, the following suggestions were made:

> Give him small, colorful servings, with new foods introduced at the *beginning of the meal.*
>
> Protect herself and the floor, and allow Peter to *finger feed.* After months of eating soft foods, a "lump" on the end of a spoon can be quite a surprise, but it is a different matter if little fingers explore it first!
>
> Keep in mind that babies are people, and no two people have the same likes and dislikes. We are not always hungry. Some days only two meals may suffice. We don't all like spinach. On hot days we may want orange sections instead of cereal. One day we may loathe asparagus, yet a month later we can't get enough of it! In these respects, baby is just like us!!
>
> Remember that the parents, as well as John and Peter, will benefit from the additional time they will have to enjoy each other's company, and that the community will benefit from the exchange of ideas with these new Canadians.

Much to everyone's satisfaction, Peter's new routine is beginning to show results. Mr. and Mrs. Apostolidis plan to attend together a neighborhood outing scheduled for a forthcoming holiday weekend.

THE RELUCTANT PATIENT

ELEANOR ROBINSON

The diabetic person who accepts his condition and conforms to its limitations intelligently can have a happy, comparatively normal existence. Failure to do so may result in tragedy.

History — Past and Present

WILLIAM MARTIN, AGED 26, was admitted with a provisional diagnosis of diabetic hypertension.

Although diabetes mellitus is considered to be an inherited disease, there was no family history of diabetes in this instance. We are told, however, that a predisposition to diabetes seems to be inherited as a recessive characteristic. It has been estimated that approximately one out of every four persons is a "diabetic carrier." This may have been the case with Mr. Martin.

He had been a diabetic since he was four years old and had spent considerable time in hospital. His present history and a physical examination revealed many complications resulting from the patient's neglect. He did not follow his diet. He tested his urine "once in a while," and took insulin "whenever he felt like it." He said he had a "good appetite" and it was concluded from his conversation that he ate what he pleased, despite his wife's attempts to encourage him to keep to his diet. He had no complaints of epigastric distress, nocturia or dysuria, dyspnea or chest pains. He was very pale with a yellowish tinge to his skin.

For the past three years he had been hypertensive. His blood pressure

---

Miss Robinson is a student nurse at St. Boniface Hospital School of Nursing, St. Boniface, Man.

was 270/120 upon admission and ranged from 174/85 to 242/140 during hospitalization. His eyesight was poor and was becoming worse gradually. Pitting edema was present, especially at the ankles. This was his chief reason for seeking medical aid. These symptoms indicated renal involvement. As a result of his condition, he was an extremely anxious and apprehensive individual. Prior to admission he had been taking three and one-half tablets of an oral hypoglycemic agent daily. This was changed to 36 units of insulin.

An x-ray disclosed that his heart was slightly enlarged. Hematological studies showed a decreased hemoglobin — 62% — that helped to account for his pallor and an increased sedimentation rate and white blood cell count that confirmed kidney involvement.

Blood sugar readings indicated a wide variation, from 55 mg. % on admission to 393 mg. %. The normal blood sugar is 80-120 mg. %.

On the evening following his admission, Mr. Martin was found in hypoglycemic shock and given intravenous glucose. Bilateral basal rales were heard and pulmonary edema was obviously progressing. An immediate electrocardiogram was done and indicated some abnormality. A chest x-ray showed "mottled changes over central portions of both lung fields consistent with pulmonary congestion and early pulmonary edema." A later report showed normal lung fields.

Rehabilitation

The rehabilitation program for this patient was very extensive although he was not a new diabetic. The aim of therapy in diabetes mellitus should be to maintain health, happiness, and as normal a pattern of nutrition as possible, while keeping the patient's urine approximately sugar-free. In managing this condition, two principles are of the greatest importance: the establishment of a dietary regimen, with or without insulin, and the education of the patient.

Treatment of Mr. Martin's immediate state was medical. It consisted of drug therapy, psychiatric consultation, social service consultation, dietary and insulin control. It was felt that psychiatric help was needed and a consultation was arranged. Mr. Martin admitted that he had tried to commit suicide some time previously by closing the garage doors and leaving the car running. Since no other attempts were confessed, it was felt that intensive psychiatric treatment was unnecessary although he would require sympathetic and understanding support. Eye specialists were consulted about his vision. Unfortunately, they felt that his sight would gradually deteriorate. The hospital social worker contacted the Canadian National Institute for the Blind asking for assistance. The patient was a music teacher and his failing vision made it impossible for him to continue this occupation.

Upon admission a 2000 calorie diabetic diet was ordered in coordination with 22 units of NPH insulin and 16 units of crystalline zinc insulin daily before breakfast. "The diabetic diet is emphatically a quantitative diet and this principle implies accurate control of the intake of food."

This fact had to be stressed emphatically since Mr. Martin often refused meals, or part of them, and asked for foods such as milk shakes and "banana splits" which he could not have. When questioned about his diet, he could explain the principles quite satisfactorily and he appeared to understand the "do's" and "don'ts." Nevertheless he refused to follow his diet even in the hospital. How closely he would follow it at home was very questionable! As long as he was in the hospital he had regular urine tests, but he admitted that he neglected this at home. He required continual supervision and encouragement as he appeared to have despondent moments when he deliberately neglected his health. Usually, he was very cooperative but he seemed to lack the initiative to care for himself without constant urging.

In spite of encouragement and close observation of his food intake, Mr. Martin continued to have a very high blood sugar. Finally it was decided to change his diet to 2000 calories and *low protein.* He was permitted greater freedom of choice of food within these limits. His insulin intake was regulated according to the percentage of sugar in his urine.

He had been faced with the problems of diabetes since early life but the complications that appeared later required many adjustments. He had to be taught how to live as a blind person. He had to learn how to face his future cheerfully. He had already received intensive instruction concerning personal hygiene, administration of insulin, care of injection equipment, urine testing, insulin reaction, and infection. His refusal to apply his knowledge constituted a major problem. The nurse's chief task was to persuade him to accept his condition, to apply his knowledge intelligently and to take a more optimistic view of the future.

CONCEPTS OF NURSING

Florence E. Elliott

To assist schools of nursing in upgrading their educational programs, the CNA has been working towards the development of a curriculum guide. This is the second of a series of three articles on this topic.

Recently a statement was made to the effect that nursing has been undergoing a social revolution. It is doubtful whether anyone familiar with the changes that have come about in the practice of nursing since World War II would seriously disagree. To those of us whose nursing careers antedate that point in history and who have been active in nursing throughout this period, the speed with which we have had to alter our preconceptions has often been dizzyingly rapid, certainly transcending that of evolution.

A nurse who had duplicated Rip Van Winkle's withdrawal from society for the last two decades would return to find nursing very different. Nurses who take up active duty after a number of years devoted to homemaking often approximate Rip Van Winkle's unawareness of what has been happening in their profession in the interim. New techniques and treatments are myriad. A whole new vocabulary seems to have developed. Empathy, acceptance, nursing problems, supportive care, nurse-patient interaction — such terms are used with a high degree of frequency. To the uninitiated they seem strange and only partially comprehensible, if, indeed, they are understood at all. Many of us who have come to see them as useful and meaningful terms may have only a limited conception of their full meaning and application.

The Scope of Nursing

The functions of nursing are rooted firmly in the ministering, comforting skills. These ministrations in the words of Frances Kreuter

> distinguish nursing care from the care of any other helping profession, the doing for a person that which he would do for himself but is unable to do, either temporarily or for a long period of time.

In the early days of nursing the functions of ministering to and comforting the patient constituted the bulk of nursing care. Nurses became so skilled in this area that nursing was considered as an art. However, nursing was not restricted for long to the performance of the simple acts of keeping the patient clean and comfortable. Such skills could be acquired easily under the tutelage of one already skilled. As medical treatment progressed, and as nursing demonstrated its value in the care of the patient, functions of a highly technical nature were allocated to nursing. These functions required new skills and a whole new body of scientific knowledge. The necesssary knowledge and skills could not be acquired other than through some form of organized instruction. The emphasis

---

Miss Elliott is the director of the study on cost of nursing education with the National League for Nursing. She presented this paper at the Curriculum Workshop, Canadian Nurses' Association in 1959.

on science and technology was great. Such a premium was placed on expertness in the performance of highly technical skills that the stereotype of the efficient, highly starched and impersonal nurse to some extent replaced that of the gentle person who "soothed the fevered brow and smoothed the wrinkled linen." As medicine and nursing progressed, the scope of nursing broadened. There was recognition that people's health needs are not restricted to periods of acute illness. Programs for the prevention of disease and promotion of health were developed. In them nursing found a role. Gradually the concept of hospital care broadened to include responsibility for continuity of care following hospitalization. Nursing extended its service beyond the hospital to the individual and his family in the community.

At the beginning of World War II, nursing was functioning on a very technical basis. Nurses were highly skilled in applying scientific principles as they carried out the therapeutic regime ordered by the doctor. Skilled efficiency in organizing and managing the workload and the patient was the order of the day. There was much verbalization about the importance of the patient. In many places the old routinized procedures were being questioned, if not discarded. Nevertheless, while the patient may have been pampered in some things, many discrepancies between the intellectual acceptance of this patient-centered concept and actual practice were quite evident. The work of the unit was still rushed so that the ward could exhibit a "spit and polish" front for the doctor, even though the patient might have wished to rest a little. The doctor often selected the mealtime for an unpleasant or painful procedure. The patient in a medical center connected with a medical school was often subjected to long clinical discussions of his condition, treatment and prognosis. The doctor prescribed the regime. The nurse carried it out. The patient's role was to accept the prescribed therapy. Public health nursing, by comparison, had made much greater strides toward true patient-centered care. The patient was considered as a member of a family unit as well as a member of society. By and large, for the staff nurse and the private nurse, nursing began and ended with the sickroom. Attention was focused primarily on disease and its treatment.

Nursing that is limited to caring for a patient by giving treatments and medications and making him comfortable may be as narrow and outdated as that viewpoint which sees the world as the centre of the universe without any thought for what we may find in outer space. Many individuals find it easier to remain caught up in consideration of worldly problems than to broaden their knowledge and to hypothesize and plan for the future in a space age. In the same way many nurses find it difficult to stretch their sights to encompass the potential for the scope of nursing that has been presaged by developments during the past two decades. This is understandable, but it is a luxury that leaders in nursing can ill afford.

The Results of Revolution

The acute shortage of prepared nursing personnel has resulted in the addition of more and more nonprofessional personnel to the nursing staff. It has brought about the assignment of tasks to the nonprofessional that were previously within the domain of the graduate nurse. New concepts of medical care have demonstrated that long periods of patient dependency upon the nurse may be harmful or even dangerous. Early ambulation and encouragement of the patient to do for himself has become a part of the accepted pattern of care. The constantly increasing number of medications, many of which must be given by injection, together with more complex treatments, have added to the technical functions assigned to the nurse. Inexorably, and perhaps inevitably, the graduate nurse has moved away from the patient. The functions that once seemed unique to nursing are delegated to workers with considerably less knowledge and skills with increasing frequency.

In her article, "A Philosophy of Nursing," Dorothy Johnson points out that, as a profession, our concepts are blurred. She discusses what can be described as the schizophrenic state in which nursing finds itself today. Some see the professional nurse of the future operating largely in a supervisory and managerial capacity. She will need nursing knowledge and skills, but in addition she will require the skills of leadership in order to direct others in the care of patients. Some believe just as firmly that the professional nurse can and will maintain, as her primary role the provision of direct care to patients.

It is not possible to predict what the outcome will be. There is much to support both viewpoints. It is even possible that the answer is that we will have both: individuals with much nursing skill and a high degree of managerial skill and, in addition, highly skilled specialists in nursing who expect to, and are permitted to, concentrate their efforts on giving a quality of care that is, perhaps, only a dream today.

Nursing Philosophy

In any setting in which nursing is practised, the quality of nursing is governed to a large extent by the philosophy of nursing that prevails in the setting. If medical practice is chiefly curative; if the nursing staff has limited experience and preparation; if there is a climate which accepts the *status quo,* the philosophy of nursing can be expected to differ sharply from that of a setting which is rich in resources; where medical practice is focused on achieving optimum rehabilitation; where an alert well-informed staff, and intelligent leadership create a climate that stimulates intellectual curiosity. The philosophy of nursing that the individual nurse professes may vary in some details. A careful analysis of nursing as it is practised will identify the prevailing philosophy. The quality of medical practice; the value system of the administration; the intellectual climate; the leadership provided; the experience and preparation of the nursing personnel; and the very concrete factor of economics which determines the number and qualifications of personnel, equipment, supplies and workload, all combine to fashion the philosophy of nursing. The quality of nursing practised may not be of the calibre for which the nurse was prepared. At first her concepts may differ markedly from those which she finds in operation. If she remains for a long enough period, her philosophy can be expected to change gradually to one that more closely approximates that which prevails in the setting.

The philosophy of nursing and of nursing education that prevails in a school and in the areas where students have their clinical experience, govern the experiences that are provided and the learning that results. Too often our philosophy of nursing has developed almost without awareness. Like Topsy, it has "just growed." However, in any school of nursing and in any nursing department in which students have experience, it is vital that the philosophy of nursing be clearly stated and understood by all.

What is Nursing?

In considering curriculum we need, first of all, to examine our underlying beliefs about nursing.

1. Nursing is a service that is performed for individuals, families and groups. It is a service performed for the general welfare of all and as such, may be considered a *social* service.

2. Nursing as a service is practised in homes, hospitals, in clinics, in schools and in industrial settings.

3. As one of the major health services, nursing has a role to play in the promotion of health, the prevention of disease and, where there is illness, restoration to health.

4. The identifying functions of nursing are its ministrations, those comforting operations that minister to the basic human needs. Bathing, feeding, toileting, dressing, listening activities are the core of nursing practice.

5. Nursing complements the activities of the other helping professions. It is unique among them, not only in the highly personalized character of its activities, but also in the continuity with which it provides its services. In the hospital, nursing serves the patient around the clock. It follows him into his home, his school, his place of business. Due to the continuous and highly personalized nature of its service, nursing is in a position to identify many patient needs, physical and emotional, that are not readily discernible to other disciplines. Nursing assumes the responsibility for recognizing these needs and for seeing that they are met. Some lie within the scope of nursing. Some require the

services of other disciplines. Thus, while one aspect of nursing is carried on under the direction of the physician, nursing also has the potential for being a contributing member of the health team rather than a second class member.

6. Nursing varies widely in degree and kind. It may be simple and elementary in nature. If it is largely custodial, palliative or for general maintenance, it can be carried on by almost anyone with a minimum of instruction or experience. It may be no more complex than the care that any wife or mother can give her family. It may be highly technical, requiring skill in many and complex nursing operations. This technical skill is based on broad knowledge of scientific principles and their application. It may be "patient-oriented," in which the method and timing of carrying out the technical operations are governed by nursing judgments. These judgments are based on *nursing diagnoses* that assess the patient's physical and emotional condition. They utilize the nurse-patient relationship in the interests of the well-being of the patient.

7. The skills of nursing derive from a great body of knowledge. This knowledge can be said to have two major components: that which is related to the body and its physical functioning and that which is related to the person and his behavior. There is, of course, a high degree of interrelatedness. In general, from the former we derive the nursing skills that are largely physical and from the latter, those understandings of human behavior which determine in large measure the effectiveness of our ministrations.

What constitutes quality in nursing? Again, let me share my ideas of good nursing care.

1. Good nursing begins with the establishment of a nurse-patient relationship that accords to the patient a status of worth as an individual, whatever his background or behavior. It communicates to him a warm and friendly concern for his well-being; a genuine interest in him as a person; a feeling of concern for his present state. It says to him, "I like you. I understand your problems. I want to help you."

2. Good nursing recognizes that a degree of dependency inevitably accompanies the early stages of illness. It seeks to communicate to the patient a willingness and ability to assume responsibility for his welfare during this time. The nurse's manner and conversation are designed to say "I am here, I have the skills and knowledge to help you. You may depend on me." At the same time, it recognizes that this dependency should be a temporary thing. It encourages progression to independency in the knowledge that this may be a major contributory factor in the return to optimum functioning.

3. Good nursing care means acceptance of the patient as he is. This acceptance transcends the narrower bounds of tolerance and is based on the concept that behavior is meaningful and has cause. Clues to an understanding of individual behavior are sought. Meaning and cause can be hypothesized from what is known of the individual's socio-economic group, his cultural group, his age group; and from what the patient and his family communicate about his past experience.

4. Good nursing care permits the patient to express his feelings without levelling any judgment on the appropriateness of this.

5. Good nursing utilizes problem-solving techniques. It observes. It analyzes what is seen and heard. It identifies the implications for nursing care. It decides on a plan of action. It implements the plan and later evaluates the effectiveness of the action, noting how it might have been more effective. This observation is used in planning a course of action in similar situations.

6. Good nursing recognizes that the patient is a person under stress. He is threatened by his illness and the possible economic consequences. Good nursing recognizes that illness is a period of tension and seeks to relieve it.

What is the relationship of nursing to the treatment prescribed by the doctor? The plan of care which the nurse devises for her patient has two major components:

1. The therapeutic regime prescribed by the doctor.

2. The nursing regime determined by the nurse (those personalized functions which are the specific field of nursing).

It is the task of nursing to fuse these two components into a well-coordinated whole that can be carried out with maximum effectiveness. The nurse has the scientific knowledge that will enable her to become technically competent in performing the nursing operations which are dictated by the situation, whether they are simple hygienic measures or highly complicated therapeutic procedures.

A Third Dimension

There is also a third dimension for nursing. It derives from the fact that the techniques are used by and with human beings. This brings into play all of the complications inherent in any situation in which more than one individual is involved. Just as the nurse turns to the biological and natural sciences for the principles to apply in developing safe and effective procedures, she must now turn to the behavioral sciences for the understanding of human behavior — her own and the patient's. This will enable her to utilize, more effectively, her technical skill and knowledge on behalf of the patient.

During this century, the behavior of man has been the object of extensive study. Research efforts have been intensified during the past two decades. The result has been a vast accumulation of knowledge which can be of extreme value to nursing. Today nursing turns to the behavioral sciences — anthropology, sociology, psychology and the related field of psychiatry — for the knowledge to use in developing skills and techniques which will enable the nurse to utilize the nurse-patient relationship constructively for the optimum welfare of the patient.

The nurse sees that the basis for developing skill in understanding others is to understand herself. She learns to ask why? Why did I choose a career that involves dealing with people needing help? How do I really feel about people in general? About the aged? About people of other nationalities, of other racial and religious groups, of socio-economic groups different from my own? What are my needs in working with people? Do I need to be needed? Do I need to be an authority? How do I react under stress? To hostility? To warmth and friendliness? To rejection? What may be the effect of my reaction on patients? What is my value system? How does it affect my actions? What do I communicate to others? Respect? Disrespect? Interest? The answers to these questions and many others can form the basis for the development of an effective nurse-patient relationship.

The nurse endeavors to understand the ways in which people react. How do they react to stress, to the unknown, to removal from the family group? What are the ways in which fear, loneliness, tension and anxiety manifest themselves? What does behavior, such as weeping, passive acceptance, demanding, mean? How can we deal with this? When can we permit dependency? When should we discourage it? Do we always obey the doctor's orders to the letter of the law? Do we sometimes bend them a little in the interests of the patient's welfare?

These represent my ideas, my beliefs about nursing, my personal nursing philosophy.

References

Ford, Myrtle, "My Personal Philosophy of Nursing," *Nursing Outlook,* Vol. 7, p. 424, July, 1959.

Heidgerken, Loretta, "Some Problems in Modern Nursing," *Nursing Outlook,* Vol. 7, pp. 395-397, July, 1959.

Ingles, Thelma, "What is Good Nursing?" *American Journal of Nursing,* Vol. 59, pp. 1246-1249, September, 1959.

Johnson, Dorothy E., "A Philosophy of Nursing," *Nursing Outlook,* Vol. 7, pp. 198-200, April, 1959.

Kreuter, Frances Reiter, "What is Good Nursing Care?" *Nursing Outlook,* Vol. 5, pp. 302-304, May, 1957.

"Viewpoints on Curriculum Development," published by *National League for Nursing,* 1957.

Nahm, Helen, "A Decade of Change," *American Journal of Nursing,* Vol. 59, pp. 1588-90, November, 1959.

Norris, Catherine, "Facilitating Student Learning through the Teacher's Use of Self," *National League for Nursing,* 1957.

We cannot always oblige, but we can always speak obligingly. — VOLTAIRE

NURSING across the NATION

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Post Convention Tour

GLOWING REPORTS HAVE been coming to National Office from members who were fortunate enough to have gone on the CNA Post Convention Tour.

Twenty-eight nurses made the trip. Leaving Halifax immediately after the convention, the plane landed at Prestwick, Scotland. From there, some of the group visited ancestral homes. Then on to Edinburgh and London where the program for the group, with visits to the Royal College of Nursing and famous health centres and hospitals, made the professional aspect of the tour very worthwhile. The reception given by British nurses was heartwarming. The number of luncheons and teas that were arranged was unexpected but greatly appreciated. The group met most of the officers of the British nursing associations.

From London, the tour visited Paris and the hospital Foch with its school of nursing at Suresnes near Versailles. To us Canadians, who think of the Old Country as not keeping up, a ride on the Mistral train from Paris to Nice clipping along at 70 m.p.h. tends to alter our thinking!

The tour then took the group to the Cote d'Azur on the Riviera, through Rome, Milan and Florence, and a visit to the buried city of Pompeii.

While in Germany the whole group attended the Passion Play at Oberammergau. This play lasted the whole day and was one of the most impressive things many of the group thought they had ever seen. It was an outstanding production and worthy of all the praise it receives. Following this a boat trip on the Rhine — a leisurely sight-seeing day when everyone relaxed and enjoyed the beautiful Rhineland.

In Geneva the group visited the International Committee of the Red Cross, the League of Red Cross Societies and the headquarters of the World Health Organization in the Palais des Nations.

Plane, bus and train transportation provided speed, variety, and opportunities for side trips and visits to unique and historical places of interest. The cuisine was good. Every report indicates that a good time was had by all.

Association Activities

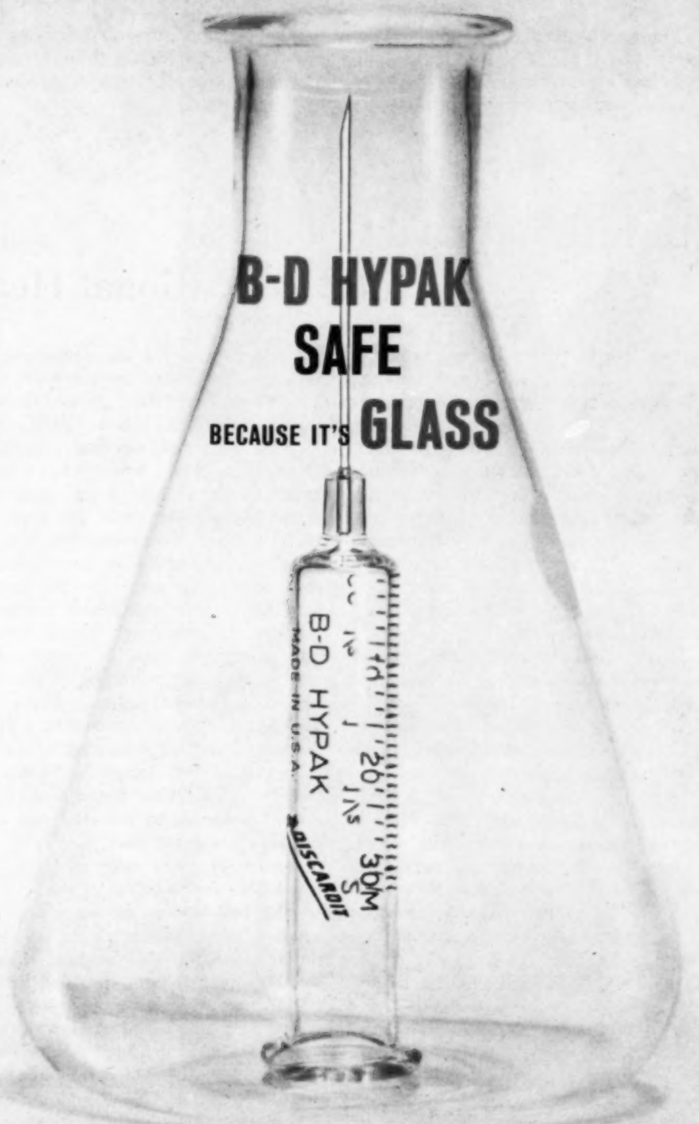
From September 5 to 10, Miss M. PEARL STIVER, the General Secretary-Treasurer, attended the ICN Exchange of Nursing Committee meeting held in London, England.

The past president, Miss ALICE GIRARD, attended the American Hospital Association convention which was held in San Francisco in September.

The National Committee chairmen met with the President at National Office in September to review committee functions and to receive suggestions for appointment of additional members to each committee, as provided in the By-Laws. The proposed activities for the present biennium were studied in the light of the available budget allocation to each committee.

Each committee will hold a full meeting to initiate projects. The subcommittees, consisting of members living in the vicinity of the chairman, will meet regularly to carry on the work throughout the biennium.

The major concern for the Committees on Nursing Service and Nursing Education will be the implementation of the first two recommendations of the Pilot Project report. The As-


B-D HYPAK
SAFE
BECAUSE IT'S GLASS
B-D HYPAK
MADE IN U.S.A.
DISCARDIT

SAFE FOR TODAY'S MEDICATIONS...AND TOMORROW'S

NO CAUTION LABEL NEEDED—Use it with **any** injectable medication...there is no danger of solvent action on the barrel. **SAFE**—B-D Control guarantees sterility, nontoxicity, nonpyrogenicity. **ECONOMICAL**—Disposability eliminates time-consuming, pre-use preparation. **PRECISE**—Exclusive tip design reduces medication loss.

B-D **BECTON, DICKINSON & CO., CANADA, LTD., TORONTO 10, ONTARIO**

B-D HYPAK, AND DISCARDIT ARE TRADEMARKS OF BECTON, DICKINSON AND COMPANY, INC. 79060

a B-D DISCARDIT product

sociation will initiate a study of the whole field of nursing education in Canada and, at the same time, conduct a school improvement program. A study of the nursing services where the students receive their clinical experience is another major project to be undertaken.

13th International Congress on Occupational Health

The development of highly technical, industrialized economies in countries the world over has occasioned various changes in ways of life — where people live, how they live, the services they require. Mechanization has increased production enormously but an efficient machine requires an equally efficient and healthy operator. Quite apart from any humanitarian interest that management feels in the well-being of the workers is the inescapable fact that the man who is healthy physically, emotionally and mentally has greater economic value.

As a direct result, the development of occupational health services is assuming ever-greater importance. The nurse and doctor in the industrial setting are familiar figures but not nearly as familiar or as numerous as needed in relation to the total labor force of any specific country.

Interest in occupational health services is international in character. July 25-29, 1960, the 13th International Congress on Occupational Health was held in New York City. A glance at the list of registrants shows that 43 countries had representatives in attendance. Finland stood proudly at the top of the list as having sent the largest number of delegates in proportion to its size and total number of health workers.

With such a diversity of cultures, simultaneous translation into English, French, German and Spanish was provided for all sessions held in the main meeting room. The compact IBM transistor sets proved most effective. It was quite common to see a delegate, his head-piece firmly clamped into position as he listened to the translator, slipping quietly across the hall to check up on proceedings at the session in an adjoining room.

The range of topics covered was extremely comprehensive. They varied from work physiology and psychology, social medicine, education and training of medical personnel to such specific subjects as industrial poisoning and the role of the pathologist in relation to Workmen's Compensation.

Speakers from Italy, Japan, Canada, the United Kingdom, U.S.A., WHO and the ILO spent a full morning presenting the various aspects of administrative practices in occupational health. Brief mention was made of the part taken by governments; types of health programs; the labor unions in relation to health. The general impression received was the great diversity in ways of handling occupational health matters from one country to another. Health services in Europe ranged from prevention of work hazards to broad protection of the physical, mental and social welfare of the worker. Dr. Sakai, Japan, noted that services in his country varied according to the size of the industry. Mr. James Matthews, an extremely forceful labor leader from the U.K., left no doubt as to the vital role that organized labor can and does play in the protection of the worker. In Great Britain, convictions for violations of the acts relating to labor had, in many instances, been brought about by union vigilance. He acknowledged the responsibility that workers should take for their own welfare. He noted that unions could take a much more active part in educating employees to observe safety measures. The co-chairman for this particular session was Miss Margaret Wheeler, past president of the ANPQ and nursing consultant, Division of Industrial Hygiene, Ministry of Health, Quebec.

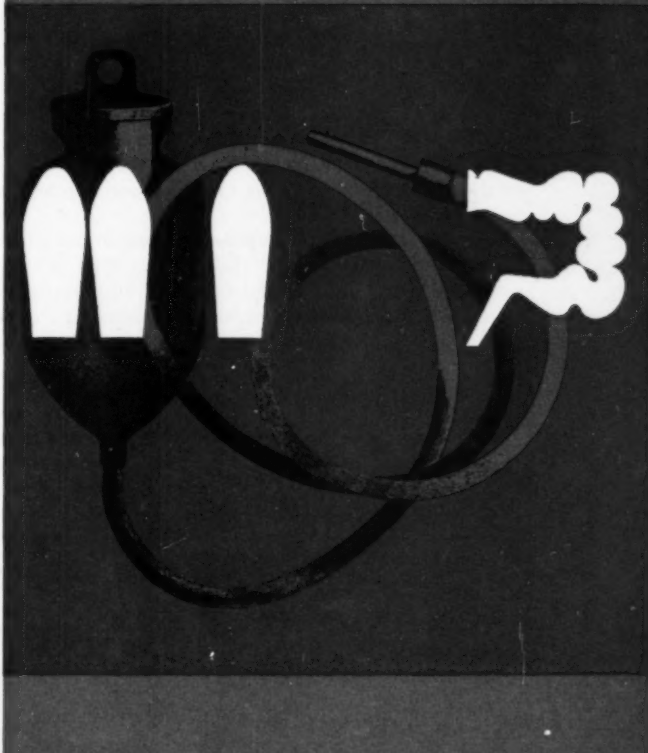
In our consideration of Workmen's Compensation, it probably does not occur to us very often to consider the role of the pathologist in deciding claims. This topic provided one of the most interesting sessions of the congress. What the pathologist finds on post mortem examination may have considerable influence in awarding compensation to a family deprived of its breadwinner.

Another highly interesting session was

ulcolax®

Reliable Evacuation without purgation by colonic contact alone

blets and suppositories



lely by contact with the colonic
ucosa, Dulcolax reflexly
oduces coordinated large bowel
ristalsis with resulting
acuation.
enerally a single evacuation of
ft, formed stool without
tharsis or straining results.
Agentle but effective laxative".*
lcolax tablets are convenient to
e for overnight action. For more
ompt effect Dulcolax supposi-
ries usually act within the hour.
lcolax Bis(p-acetoxyphenyl)-
pyridyl methane, yellow enteric
ated tablets of 5 mg in vials of
and bottles of 100; suppositories
10 mg in boxes of 6 and 50.

rchambault, R.: Canad. M.A.J.
:28, 1959.

igy Pharmaceuticals
der license from
H. Boehringer Sohn,
gelheim

ontreal

L-1278

patient goal:

beautiful fingernails

physician Rx:

Knox Gelatine

Brittle fingernails are a real source of distress to women so afflicted. That's why it's important to be able to provide more than psychological support for such patients.

Knox Gelatine restores normal nail strength in approximately 80 per cent of patients with brittle laminating fingernails. This fact has been confirmed by four independent clinical studies involving 122 subjects. Dosage is one to three envelopes of Knox Gelatine per day and improvement usually begins within 30 days.

One point needs special emphasis. Research has established that the entire envelope of Knox Gelatine (120 grains) must be taken in a single dose to provide the dynamic effects necessary to correct the brittle nail defect. Consequently, fractional or divided doses are contraindicated. If you would like to examine the substantiating studies just use the coupon below.

KNOX
UNFLAVORED
32
GELATINE

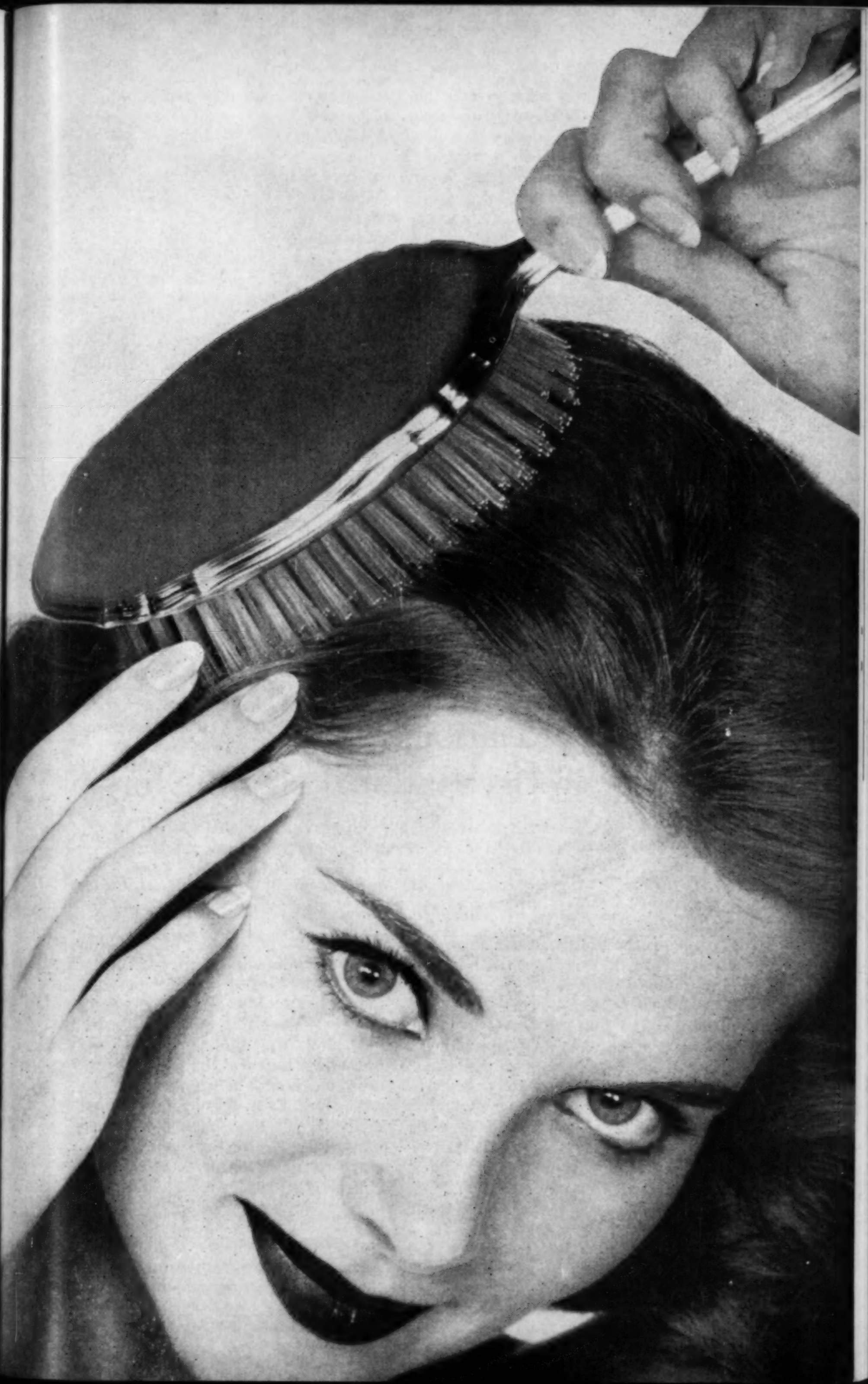
©1959 Knox Gelatine, Inc.

KNOX GELATINE (CANADA) LIMITED
Professional Service Department
140 St. Paul St. West, Montreal, Quebec,
Dept. CD-11

please send reprints of the following articles:

☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

Your Name and Address



devoted to the different aspects of health services in industry. Nurse delegates took chief responsibility for the information presented. One speaker discussed the steps necessary in initiating such services in an industry. A requisite is an informed management prepared to give enthusiastic cooperation. It may often fall to the lot of the nurse to "sell" the idea that such a service is in the interests of management. She must be prepared to support her position with sound facts.

The doctor and the nurse in industry are confronted with somewhat unusual problems. The doctor does not have the usual freedom of choice in patient selection. His relationships with his patients are affected by the fact that both doctor and patients have a common employer. The opinion was expressed that the status of the doctor in industry is less satisfactory than that of the nurse. There is a tendency for his confrères to look down upon him because his patients are in the laboring class; because he is somewhat less than his own master. The nurse retains her status but is likely to be subjected to pressures to forego professional norms when they conflict with those of business.

A speaker from the United Kingdom described a successful experiment in setting up an occupational health unit as one of the services of a general hospital. The Central Middlesex Hospital, England serves an area that includes about 1,000 factories. For many employees in industry in this area, it represented the first time that a visiting nurse had appeared in their factory. It required tact, diplomacy and considerable commonsense to win acceptance of the service and achieve effective working relationships.

Finland presented a somewhat different picture. Employment of a nurse by a firm is regarded as an optional social service. Educational programs for nurses in industry are in a state of early development.

Occupational health is one of the developing fields in the nursing and medical professions. While accepted as a necessary facet of policy by many large firms and some smaller ones, much still remains to be done in making the health care of the worker a part of general health services.

J. E. M.

Intergroup Relations in Occupational Health Nursing

CHARLOTTE EPSTEIN, PH.D.

The challenge to the occupational health nurse is probably one of the most interesting in our society today.

Changes in Industry in the U.S.

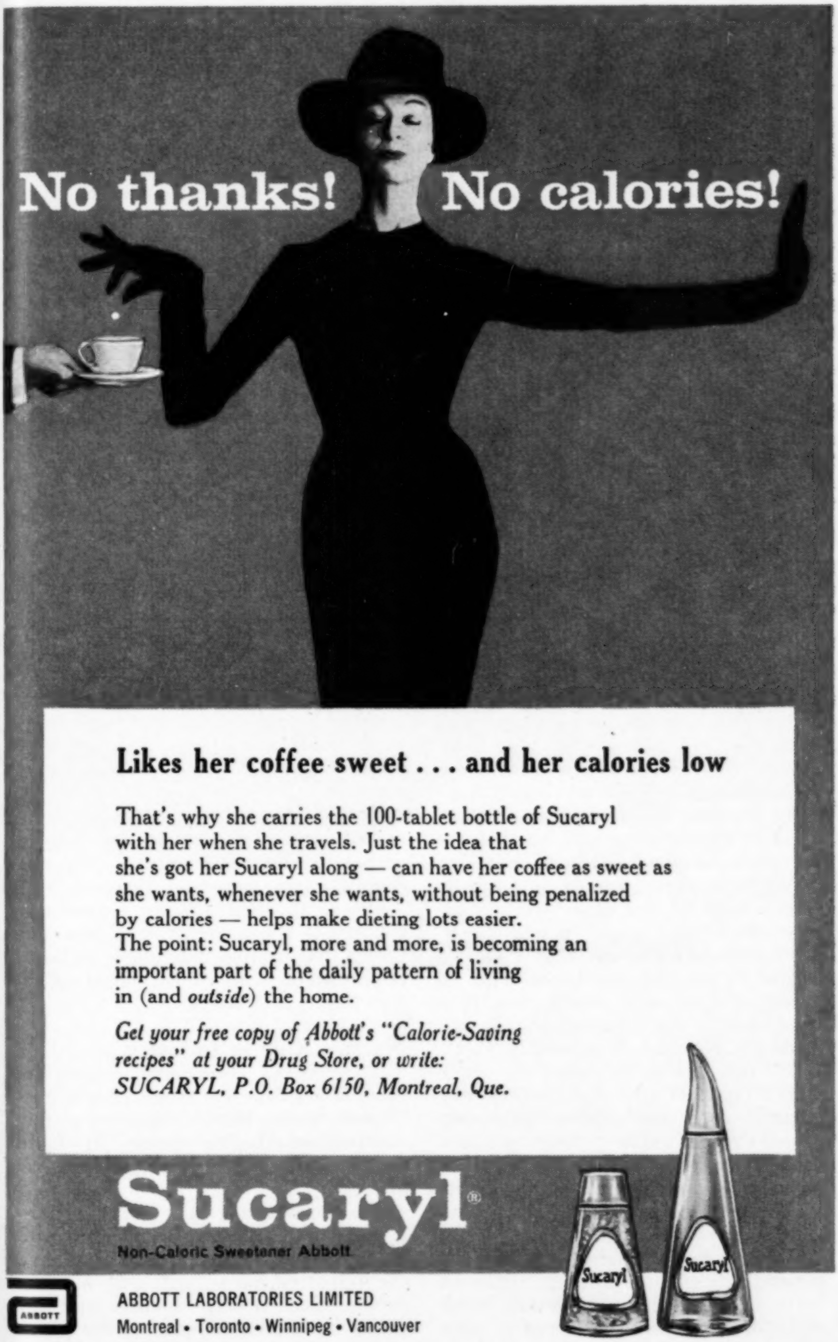
PROFESSIONAL CONCERN with occupational health is by no means a new thing. McGee[1] notes that the oldest medical literature available describes injuries that may have been sustained in the building of Egyptian pyramids. However, contemporary developments in industry and medicine suggest that this may be the time to extend our definition of industrial medicine.

We have customarily considered industrial medicine as concerned with "the study and control of the inherent and environmental factors affecting the health and well-being of persons at their places of work."[2] We have not, however, generally been aware of the fact that the "environment" of an individual includes the person working next to him. The implication for an extension of the definition of industrial medicine is that the physician and nurse who work in a plant must learn much more about the social-psychological factors involved in human interaction than they presently do in schools of nursing and of medicine.

The United States, with its unique pattern of intergroup relations, presents an interesting case history of the

---

Miss Epstein is assistant professor of human relations at the University of Pennsylvania, Philadelphia.



Likes her coffee sweet . . . and her calories low

That's why she carries the 100-tablet bottle of Sucaryl with her when she travels. Just the idea that she's got her Sucaryl along — can have her coffee as sweet as she wants, whenever she wants, without being penalized by calories — helps make dieting lots easier. The point: Sucaryl, more and more, is becoming an important part of the daily pattern of living in (and *outside*) the home.

Get your free copy of Abbott's "Calorie-Saving recipes" at your Drug Store, or write: SUCARYL, P.O. Box 6150, Montreal, Que.

Sucaryl®

Non-Caloric Sweetener Abbott

ABBOTT LABORATORIES LIMITED
Montreal • Toronto • Winnipeg • Vancouver

effects of industrial change on industrial health. Let us look at some of the changes that have occurred in industry recently, and let us see how these changes affect the industrial nurse.

During the last war, the American government inserted in its contracts with private industry a clause which provided that people were to be hired on the basis of skill without discrimination as to race, religion, or national origin. As a result, many industrial workers found themselves working with people who belonged to groups with which they had had little or no contact previously. White workers who were informed that Negro workers were coming into a factory on all jobs were often disturbed at the prospect of employment on an equal basis with Negroes. As in the case of male employees who suddenly find females assigned to the same tasks that they have been doing, white workers were often bothered by the fear of loss of status. They felt that Negroes working as their equals would "pull them down" in their own eyes and in the eyes of their friends. They spoke vaguely of "trouble" that might result from such integration. They frequently threatened to leave their jobs. But in instances where the firm's policy was upheld and workers were told that, though their fears and doubts were understood, the problems would have to be resolved in the course of working with all Americans as equals, production went on as scheduled.

Negro workers coming into plants where Negroes had never worked before often came in with trepidation. They worried about how they would be treated. They did not know what to expect. Often they found that they were quietly insulted, ostracized, and made to feel generally miserable.

But this was by no means the whole story. The fact that the country was engaged in a war against dictorship caused considerable inner conflict between on the one hand, belief in democracy and, on the other hand, the reluctance to give all people an equal opportunity for employment. In addition, the war gave impetus to general fair employment legislation on both state and municipal levels. More and more workers were forced to come face to face with their own prejudices and fears regarding integration. Today, the idea of extending civil and human rights to *all* people is spreading. With it comes the inevitable conflict that accompanies great change in group relationships. In addition to public agencies, a complex network of private agencies has grown up in the United States whose activities are mainly dedicated to alleviating conflict, using it creatively, and helping people to adjust to the shifting group relationships.

All of these changes have resulted in a growing awareness of people for each other across group lines. We no longer take each other for granted. We look about us and wonder about the motives, expectations, and feelings of other human beings. We worry that we "won't know what to say and how to act" when we find ourselves with people of other races or religious beliefs. We are afraid of people with whom we have rarely associated, about whom we really know very little, and of whom we have always heard derogatory stories.

Even those factories that have never employed more than one national, racial or religious group must soon come to grips with this situation. Migration into the United States is at an all-time high. New people are coming into most industrial areas in very large numbers.

Industrial medicine may have begun out of concern for mechanical safety, proper working temperatures, physical comfort and industrial diseases and injuries. It must rapidly extend its concern to a consideration of how the things that trouble individuals in their relationships with other people affect their health and safety.

Nurse's Role in Industry

Though the component groups in Canada are different from those in the United States, the effectiveness of the occupational health nurse in both countries depends on similar operative factors.

The nurse's role in industry is unique — quite different from the role of the nurse in the hospital. Essentially, the industrial nurse deals with *healthy* people. Occupational diseases and injuries have been reduced to the point where they account for only slightly

go ahead, dunk it . . .
water won't hurt your
Ident-A-Band®

You don't need to pamper an Ident-A-Band . . . even under water. There's no risk of a blurred name or a soggy, dissolved identification card that might lead to mistaken identity. Every Ident-A-Band card is specially treated to withstand both wear and water. And you seal it permanently *inside* the strong, transparent band itself. The important patient's card stays in . . . and it stays legible, when it's in an Ident-A-Band.

the original
the positive **Ident-A-Band**®

HOLLISTER®
LIMITED
160 Bay St., Toronto 1

over 10 per cent of working days lost. The healthy person has problems and reactions that are somewhat different from those of the ill person. The behavior of the healthy person must be considered in terms of his home life, his social life, his job satisfaction. He has not been suddenly uprooted from his every-day experiences and deposited in a hospital bed where he is at the mercy of new rulers and unfamiliar routine. He must be approached as a mature individual, in reasonable control of himself, and committed to a certain way of life. The emphasis of the work of the industrial nurse must shift more and more into the area of prevention and psychological prophylaxis.

People who are disturbed for any reason are likely to be less competent on the job. If they dislike, fail to understand or fear the people with whom they work; if they resent the boss; if they are discouraged by the depersonalization of mechanical and repetitive work, they may injure themselves, do injury to others, or just not do the job that should be done. The industrial nurse is in a strategic position to take the lead in helping people solve their problems.

Prevention of illness and accident, and correction of maladjustments require a very broad knowledge of the sociological, psychological, and human relations factors that influence the behavior of people. As a first step in prevention there must be an awareness of the various facets of the many interpersonal relationships in a plant.

Nurse-doctor Relationships

Not all firms have a full-time physician. Smaller industries may have a physician on call only for major injuries. The degree of cooperation between doctor and nurse may vary considerably. Some doctors may require little of the nurse excepting the most routine record-keeping. Others may delegate authority to a degree that makes her wonder if she is violating the law against practising medicine without a licence. The problem is not insoluble. Lines of communication between doctor and nurse are not always clearly defined. In some cases the doctor sets the policy and gives the orders but he does not always sit down and discuss with his nurse, as an equal, their areas of jurisdiction and operation; the areas in which one is able to operate more effectively than the other, where one can do more good than the other.

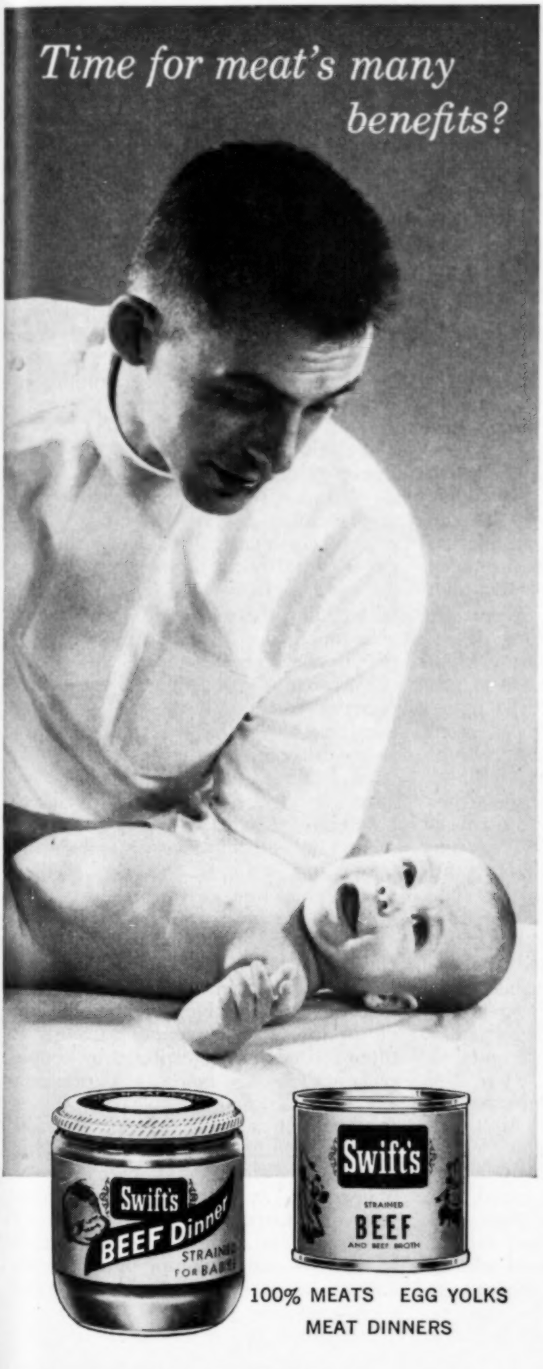
The Nurse's Role

It should be admitted that, in many areas of industrial health, the nurse is in a better position to work effectively than the doctor — especially if she is a full-time, regular employee. She is always there when she is needed. She never requires a special call or an appointment before she may be consulted. For the well person who is grappling with a problem, the opportunity to confide in the nurse — someone sympathetic, possessing a certain knowledge and authority — is enough to send the worker back to his job feeling considerably relieved and at least temporarily able to keep his mind on his work.

Nor is the nurse confined to her infirmary or her office. She can go out into the plant; see the men and women at their machines and benches; stop for a word here and there; inquire about a cold or a cut finger; and generally make it known that she is available on an informal basis. Workers soon come to accept the fact that they have someone in the plant who is professionally trained to understand their problems, and who presents no financial blocks to consultation. If, in addition, the nurse has been able to build for herself a reputation of impartiality, insofar as taking sides between management and labor is concerned, then there is no limit to the confidence that will be placed in her way by both sides.

It is not a simple matter to develop such a reputation. In her very attempts to make purely professional decisions as to whether or not an employee may safely return to work after an accident or illness, she may come into conflict either with middle management or with the worker. It will require extraordinary tact — and even planned strategy — to convince management that the worker should not return to the job or to convince the worker that he really should.

In her visits to the plant, the occupational health nurse learns more about the people in her charge than any



Time for meat's many benefits?

...then it's time to trust SWIFT ...the meat specialist!

Swift's 105 years of experience as a *specialist* in fine meats benefit your little patients in two important areas.

First, for optimal nutrition, we select *leaner* meat with its higher protein content . . . process carefully to retain vital nutrients.

Secondly, to assure the emotional satisfaction that results from easier feeding times, we strain our meats smoother. And the flavours are so appetizing they aid in establishing sound eating habits early.

Only Swift *specializes* in meats and meat dishes for babies.

The two most trusted words in meat...

Swift's Premium

100% MEATS EGG YOLKS
MEAT DINNERS

other member of the organization. Since knowing your students is a basic prerequisite for effective teaching, the plant nurse who mingles with the workers and keeps a sharp eye open to detect unhealthy attitudes and other problems, can do more effective teaching informally and almost "off-the-cuff," than all the posters, directives, and health-and-safety campaigns put together. For example, repeated public display of impartiality by the nurse can do much to help individuals accept members of different religious and racial groups. At the same time, the nurse can let people know that she understands their fears and doubts about associating with people different from themselves; that she is ready to help them work these fears through. It may be accomplished through discussion and examination of their feelings. Often, it is possible for the nurse to find herself in a group at the time of a coffee break or at lunch. She can be instrumental in starting a discussion about problems that she has seen developing. Nobody knows better than nurses that people talk to nurses, about everything and anything. Talking is an excellent first step in tackling psychological problems. At least it is an opportunity to discover the existence of such problems. They are often hidden and smoldering, ready to erupt at the first sign of change.

The nurse must first overcome her own reluctance to discuss "controversial" problems. There is an idea current in our society that it is better not to discuss race, religion, etc. The basis for this idea seems to be that these subjects are so overlaid with strong emotions, that people are unable to discuss them without becoming violent and unfriendly. There is the additional idea, too, that it is better to keep this potential violence quiet — "let sleeping dogs lie."

It is rather easy to demonstrate the fallacy of both ideas. We are all aware to some extent of what is going on in our country these days. The relationships between the various racial and religious groups are shifting and changing. People are no longer sure of where they stand in the general scheme of things. They welcome the opportunity to discuss their feelings of uncertainty. They are curious to know how other groups feel about the situation. A good discussion leader can keep such a discussion within reasonable emotional bounds and help the group develop the feeling that they are not alone in their uncertainty and fear.

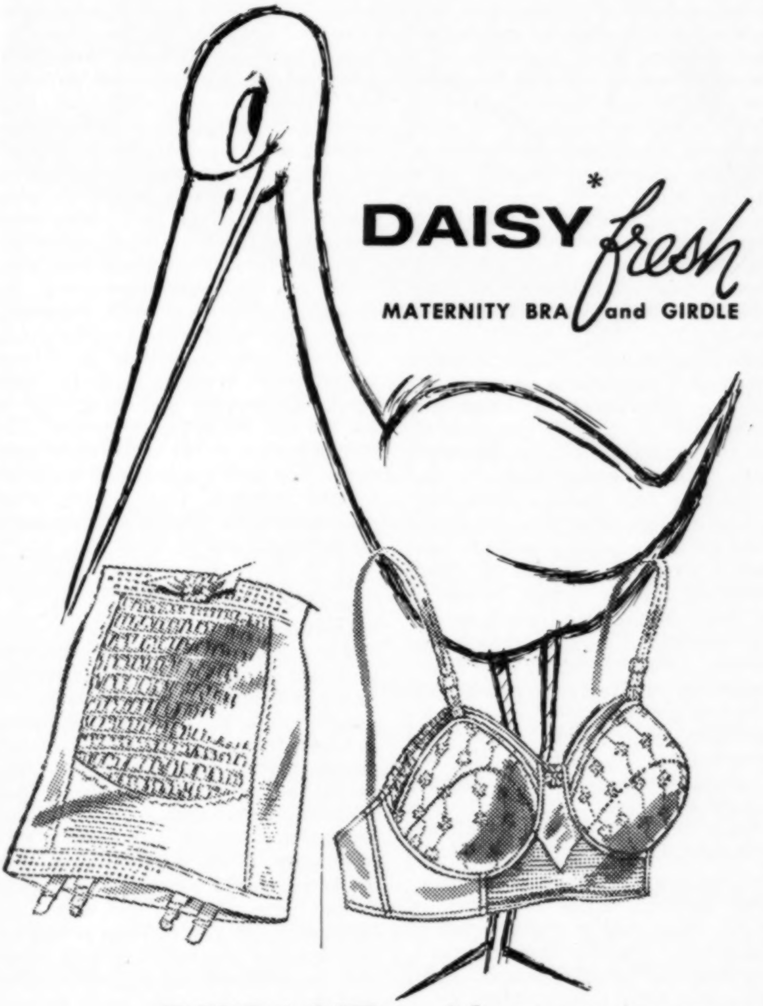
To think that "sleeping dogs" can remain asleep forever is specious. The world is too small today for us to think that any social problem can be avoided indefinitely. It makes much more sense to try to figure out how to cope with a situation before it becomes a crisis. Cool heads are much more likely to look at an advancing problem realistically; to consider how everyone is likely to be affected by it; to plan how to solve it with a minimum of difficulty.

Psychological and Sociological Factors

What are some of the psychological and sociological facts that are particularly pertinent to the work the occupational health nurse is trying to do? Although we may be reluctant to admit that there are different socio-economic groups, the fact remains that people of different financial and social backgrounds *do* demonstrate differences in behavior. Unless these variations are recognized for what they are — as different approaches to life, different values, different tastes — we have a tendency to be shocked, disappointed or repelled when we encounter them. Instead of accepting them as interesting, we tend to feel that they represent an interior form of life.

Language is a form of behavior that varies rather obviously from social class to social class. Often it becomes a basis for rejection or suspicion. The direct, frank, voluble, loud expression of the lower socio-economic groups is often erroneously interpreted by people with middle-class modes of expression as threatening and unpleasant. It is reasonable to assume that if we consider a person unpleasant because of his speech, we are less likely to try to understand and to appreciate him. Choice of words and tone quality may constitute an almost impenetrable barrier to understanding and acceptance between individuals of different socio-economic groups.

Prejudice and discrimination affect



EXPAND *without pressure...*

When your heir is apparent, baby yourself with the sure, gentle support of Daisy Fresh.

The all elastic pull on girdle expands as naturally as you do. Inner bands provide a cradle of comfort. The embroidered cotton bra is well elasticized and constructed to change to your exact size just as easily and pleasantly.

Naturally, being Daisy Fresh, they're doctor approved designs.
At stores throughout Canada.

DOMINION CORSET CO., LTD., QUEBEC, MONTREAL, TORONTO, VANCOUVER

different people in different ways. They can often result in walls of ignorance and hostility between groups. When we think of our own lives, we realize how little friendly association most of us have had with people of races, religions, and nationalities different from our own. We have lived among people like ourselves, played with them as children, gone to school and probably to work with them. Where, then, have most of us had the opportunity to get to know people of other races, to understand their problems, and to appreciate their aspirations? As a consequence, we have a tendency to view with suspicion, accept with reluctance, or reject categorically people who appear different from us.

Separation between groups assumes even greater proportions when we realize the differences in experience encountered by minority-group members and members of the dominant group. Minority-group members can not rent or buy homes where they might wish, even when they can afford it. The most respectable, well-educated family is over and over again refused the sale of a home merely because it is a Negro family or a Jewish family.

In education, too, minority-group members often meet rejection and disappointment. Italians are refused admission to medical schools merely because they are Italians; Jews face quota systems in colleges; Negroes are compelled to go far afield because tax-supported, state universities in the area in which they live will not admit them.

In employment situations minority-group members know the story of evasion, delay, and outright refusal of employers to consider them on merit. They know of school guidance counsellors who steer their children away from chosen and desirable careers on the premise that they "won't have a chance in that field." They have experienced year after year of stagnation in menial jobs because upgrading was denied to them.

With such experiences, such memories, minority-group members necessarily become "different." People who have not had such expeiences simply cannot understand or appreciate minority-group feelings and attitudes, unless they make an earnest effort to develop such understanding.

On the other hand, members of the dominant group are also prey to experiences that result in certain attitudes. They hear stories about other races and religions that are too frequently garbled, distorted, and false. These stories are repeated so often and questioned so rarely that they come to be accepted as truth. Unfortunately we are not taught, as a general rule, to doubt, to question and to check all generalizations about other people. It is much easier and more comfortable to accept those generalizations and to act as if they were true.

As a result, dominant-group individuals, when faced with the necessity of associating with minority-group members, often refuse to participate with them in common projects. They react with hostility and antagonism to the thought of such participation. The fear of loss of status is the underlying motive for such reactions. It is similar to the reaction that occurs when women workers come into departments for the first time.

The Occupational Nurse as Educator

The nurse is in a strategic position to utilize all the foregoing facts, since, in her function as health educator, she can appreciate the effects of these psychological and sociological factors on the behavior and attitudes of the people in her charge. She must have a sound understanding of educational principles, and skill in educational techniques, if she is to fulfill her aim of better health on the job. How people learn, why they will or will not learn, and how to teach them to *want* to learn are all problems with which the occupational health nurse must concern herself. She must develop skill in problem-solving and in encouraging free exchange of ideas and expression of opinions. She must be able to teach role-playing and to give discussion leadership in order to help people in their problem-solving efforts. She must be aware of the availability and effectiveness of visual aids. She must be aware of community resources so that she may call on them whenever necessary to supplement her own knowledge and skills.

more
to Pour
than ever
before

he
Pour
Bottle
system

In operating room, pharmacy, central supply, laboratory...in fact, all over the hospital, more solutions are being poured than ever before in irrigation, washing and rinsing procedures. Pour bottles fill mmediate needs for sterile uniform solutions—and hey keep right on working since they can be re-used s dispensing or storage bottles for hospital-prepared tems and as drainage bottles. Let our representative xplain the complete **pour bottle system** for economical se—profitable **re-use**...or write for illustrated brochure.

AXTER LABORATORIES OF CANADA LTD.
ALLISTON, ONTARIO

DISTRIBUTED BY
INGRAM & BELL, LIMITED
TORONTO • Montreal • Winnipeg
Calgary • Vancouver

Education for Occupational Nursing

This has not been an attempt to cover the vast field of intergroup relations in occupational health nursing exhaustively. It is hoped that the views expressed will indicate the need for more emphasis on this aspect of the profession in schools of nursing. Occupational health nursing is a rapidly expanding field. More adequate preparation is required for the nurses who enter it so that they may deal more effectively with the unique problems that they encounter in their work. Though it is true that all professional people must continue to study and learn while they work, there is no substitute for the basic orientation and systematic preparation that schools can provide. The occupational health nurse is denied this advantage presently.

Knowledge of occupational health should not be reserved only for those nurses who plan to make it their career. In an industrial society such as ours, every nurse should be aware of the effects of work situations on people. The patient who comes to the doctor's office often comes from an industrial job; the patient who leaves the hospital goes back to industry. The nurse who knows nothing about the situation in which her patient functions, is seriously handicapped in her understanding of him as a person.

The job of conserving health through supervision, treatment, and education is a vital and continually expanding concept. It deserves the growing concern and activity of the best prepared and the most enthusiastic people in our society today.

References

1. McGee, Lemuel C., *Manual of Industrial Medicine*. Phila.: U. of P. Press, 1950, p. 1.

2. *Ibid.*, p. 7.

Learning is essential for a successful life, but it is also a source of much pleasure.

Acquisition of one's language is indispensable, because without language, it is impossible to clearly express and explain one's ideas.

The study of several languages enlarges intellectual horizons and results in better understanding of many things. History, which tells the story of the knowledge and experiences of men down through the centuries, enables gifted men to see the events of contemporary life in their true light; it permits better judgment with a wider perspective. The pupil draws from the study of mathematics and ability to reason quickly, correctly and logically. And the sciences transmit knowledge of nature that man never ceases to accumulate.

ance Co. of Canada.

The Value of Education, Sun Life Assur-

A cheap preventive for decubitus ulcers caused by the friction of bedclothes, is a sheepskin bedcover. It is resilient, soft, absorbent, airy, non-abrasive and does not wrinkle. The cover is changed every three to seven days, cleaned with a mild soap and spray and allowed to dry in the open air. After drying, the wool can be fluffed to its original state. — *Abbott Abstracts*

Stress-induced overactivity of the adrenal glands may be an answer to how the body translates high-tension living into excessive amounts of cholesterol in the blood.

Adrenal injections are capable of raising the blood cholesterol and other lipids in normal dogs. If the adrenal glands are removed, thus depriving the animals of cortical secretions, the effect of adrenalin injections is lost. When cortical secretions and adrenalin injections are given, the fat-mobilizing potency of the adrenalin is restored.

There may be, therefore, a direct cause-and-effect relationship between adrenal overactivity and the rise in blood lipids seen in various studies of men who were subjected to disturbing emotional experiences or sustained high-level job performance at a forced pace.

— U.S. Department of Health, Education and Welfare.

* * *

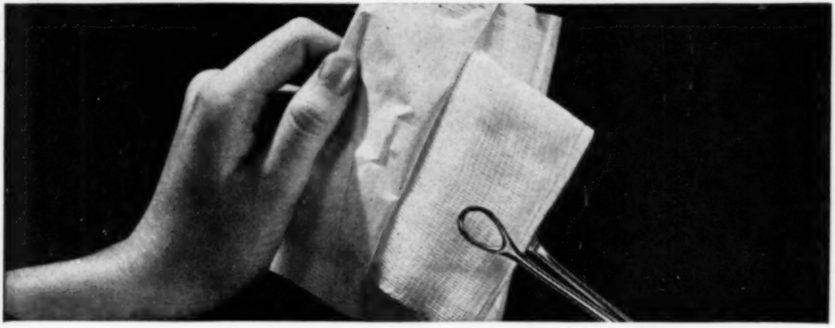
A compact, dry, chemical fire extinguisher is available for use in the home. The chemical is effective against all types of fires, e.g. wood and paper, grease, gasoline and oil, and electrical fires in cars, refrigerators etc. Compressed air expels the powder; the unit does not require refilling until used and if unused, the powder will last a lifetime.

— *Bulletin No. 73,* Dept. of Labor, Ottawa.

NEW PRE-PACK OPENS ASEPTICALLY

...in one simple motion!

all one motion: pull tab . . . dressing's ready . . . one hand's free



New S-E Pack keeps dressing sterile from package to patient. Opens without scissors or string—dressing never touches torn, unsterile edges.

An ingeniously simple wrap now gives you Cover Sponges that remain totally sterile—even during their removal from the package. There's no contact with hands or unsterile edges. Completely aseptic, at a time when strict adherence to aseptic technique is a main line of defense against hospital staphylococcus. 1, 2, 3, et. al.

In addition to much-wanted safety, you have the much-proven pre-pack efficiency that yields steady dividends in terms of time gained, labor spared and money saved.

For the latest—as well as the safest—in hospital dressings, use Curity.

1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

Curity® TRADE MARK S-E* Pack

THE KENDALL COMPANY
(CANADA) LIMITED
BAUER & BLACK DIVISION

*T.M.

NURSING PROFILES

Alice Lilian Wright, who has been the executive secretary of the Registered Nurses' Association of British Columbia since 1943, retired the end of August.

(Hannay)

Alice Wright

Born and educated in Charlottetown, P.E.I., Miss Wright was in her 'teens when her family moved to Vancouver, B.C. Following her graduation from the school of nursing, Vancouver General Hospital, in 1918, she served as a head nurse there for two years before migrating to the United States to work as so many young nurses do today. Specializing in pediatric nursing, Miss Wright secured her Bachelor of Science degree at Teachers College, Columbia University, then joined the faculty of the pediatrics department at the Columbia-Presbyterian Medical Center in New York. During her years in this field, Miss Wright made an interesting collection of ancient nursing bottles.

The development of districts and chapters, as the framework of the provincial association activity, was in its infancy when Miss Wright assumed her responsibilities with the RNABC. Firmly believing that the expanding membership would be more interested in active participation in the affairs of the association if they knew their secretary personally, she not only took part in chapter organization activities but planned for regular, repeat visits. An ardent photographer, Miss Wright made international and national nursing figures come alive to her audiences as she reported the meetings she had attended.

Nor were her activities limited to British Columbia. Through her quiet leadership, the conference of provincial executive secretaries and registrars has played an increasingly important role in inter-provincial nursing developments. Miss Wright was invited to assist the nurses of New Brunswick in their initial analysis of the nursing needs of that province.

Though she has retired, Miss Wright has every intention of continuing her lively interest in the problems of nursing. A member of the I.C.N. Membership Committee, she plans to attend the Quadrennial Congress in Melbourne next April. She will maintain her residence in Vancouver.

(Sherick)

Eleanor S. Graham

Succeeding to the post of executive secretary of the RNABC is **Eleanor Scott Graham** who has functioned as assistant since her return to Canada last year after five years of service with World Health Organization as supervisor of nursing for Southeast Asia, with headquarters in New Delhi, India. A British Columbian by birth, Miss Graham engaged in public health nursing following her graduation from Van-

...and you have a HEADACHE!

"217"
TABLETS
the wonder combination for
PROMPT, SUSTAINED RELIEF

Acetylsalicylic acid	3½ gr.
Phenacetin	2½ gr.
Caffeine Citrate	½ gr.

Available in Handy Tubes of 12
Economy Sizes of 40 and 100

Charles E. Frosst & Co.
MONTREAL, CANADA

couver General Hospital and the University of British Columbia. During her postgraduate study at the University of Chicago, where she secured her Master of Science degree, she specialized in administration. She found the principles equally applicable to her work as one of the assistant directors at the National Office of the Victorian Order of Nurses in Ottawa and as director of nursing at Royal Columbian Hospital, New Westminster, B.C. Miss Graham has travelled the length and breadth of the province during this past year, meeting the nurses in their own environment and developing a broad understanding of their needs and problems.

The Alberta Association of Registered Nurses has appointed **Helen Mary (Garfield) Sabin** as its new executive secretary. Born in British Columbia, Mrs. Sabin came to Alberta at an early age and received much of her basic education and her professional preparation in that province. A graduate of University of Alberta Hospital, Edmonton, she holds her B.Sc. in nursing with a major in public health.

(McDermid Studios Ltd.)
HELEN SABIN

In the intervening years between graduation and her present appointment, much of her professional life was spent in the public health field in various parts of Alberta. For two years she was nurse in charge of the Social Hygiene Clinic, Calgary, A year as clinical instructor at the University of Alberta Hospital was followed by a year of school nursing in Edmonton.

Off duty she enjoys an outdoor life — curling or hiking as the seasons permit. Apart from this she has devoted considerable time to Girl Guide and Boy Scout groups, teaching St. John Ambulance classes and to participation in various aspects of church work.

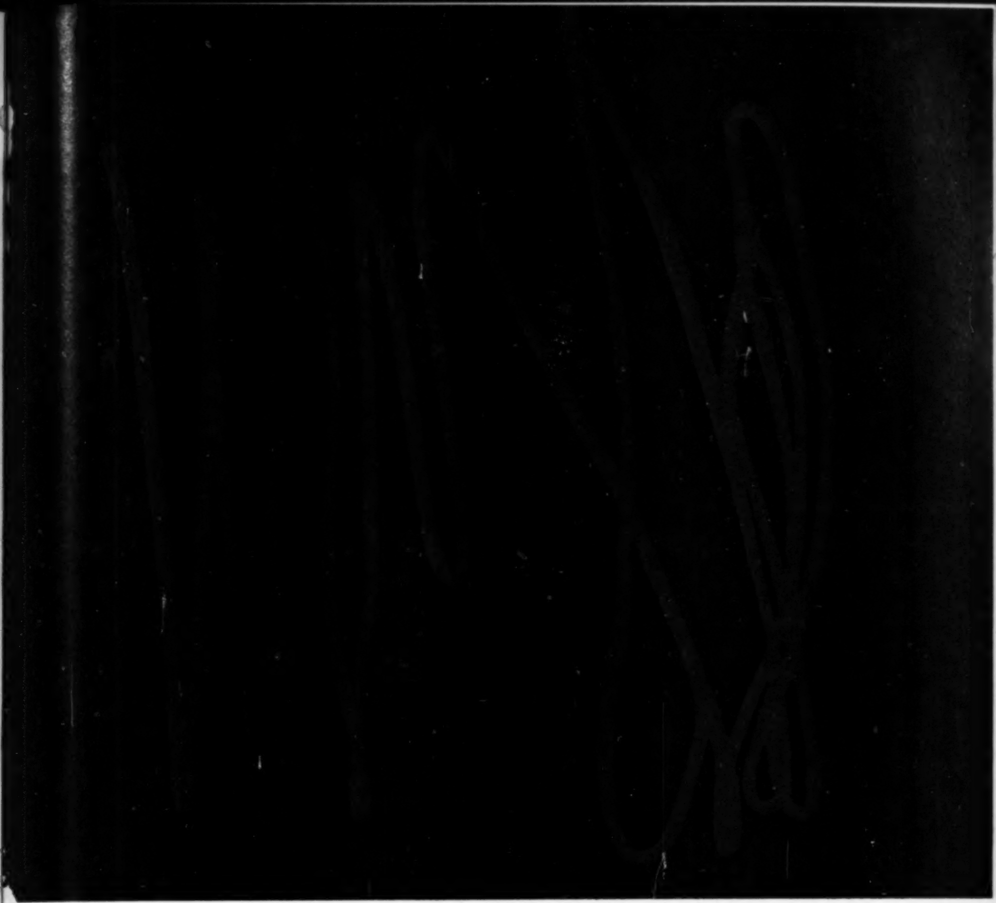
MARJORIE MILLIGAN

Marjorie Kerr Milligan, executive director of Montreal's Child Health Association retired during this past summer. A graduate of Royal Victoria Hospital, Montreal, Miss Milligan studied administration and supervision in schools of nursing at McGill University.

Shortly after her graduation she joined the nursing staff of the Alexandra Hospital, Montreal, first in the capacity of night superintendent and then as a medical follow-up worker. Her first contact with the Child Health Association came in 1928. Beginning as a staff nurse, she was supervisor of CHA's health service division in 1937. In 1943 she became assistant to the executive director, succeeding to the directorship in 1950.

Her retirement from the agency that she has served so faithfully will occasion considerable regret. Good wishes are extended for a satisfying and happy future.

It is always a matter of general pride and pleasure to other members of the profession when one of their number receives signal honor for her professional service. **Edith Davis Kemp,** supervisor of nurses at the Provincial Mental Hospital, Ponoka, Alta,. was named the "Psychiatric Nurse of the Year" in June this year at the Cana-



that important line

between safety...and a lost sponge

...always an unmistakable pattern. Cannot be confused with bone structure or artifacts on x-ray plate.

Helping the hands that heal

Made in Canada by Johnson & Johnson LIMITED MONTREAL

NEW BLUE LINE
RAY-TEC
X-RAY DETECTABLE
SPONGES

RAY-TEC is a trade mark of Johnson & Johnson Limited

dian Mental Health national conference. Miss Kemp is a graduate of P.M.H. and the Royal Alexandra Hospital, Edmonton. In conjunction with this special recognition, she was awarded the Marjorie Hiscott Keep White Cross Medal given in memory of a pioneer in the field of psychiatric nursing. On behalf of friends and colleagues in her profession, we extend warm congratulations.

Ann Beckingham, a 1953 graduate of the Montreal General Hospital, recently undertook what promises to be an exciting new assignment when she joined the American University of Beirut, Lebanon. She is an instructor and supervisor in general nursing at this institution.

ANN BECKINGHAM

Miss Beckingham completed requirements for her Master's degree in nursing service administration shortly before leaving to take up her new position. Her professional career since graduation included night supervisory work, assistant and head nurse experience at the Montreal General Hospital; operating room experience at the Jackson Memorial Hospital, Miami and at St. Luke's Hospital, New York City. Her new duties and, in particular, her new environment will provide her with a wide range of interesting experiences.

Doris Janet (Watson) Seager has been appointed to the professional staff of the AARN provincial office as assistant executive secretary. She began her duties early in July. A graduate of the Winnipeg General Hospital, Mrs. Seager obtained her diploma in teaching and supervision from the University of Manitoba and similar qualification in administration in schools of nursing from McGill School for Graduate Nurses.

(McDermid Studios Ltd.)

DORIS SEAGER

She was the science instructor at the Galt School of Nursing, Municipal Hospital, Lethbridge for several years before joining the staff of Aberhart Memorial Sanitorium, Edmonton as clinical instructor. In 1953 she became associate director of nursing service, Royal Alexandra Hospital, Edmonton. For a few months prior to her present appointment she was the northern supervisor for the Junior Red Cross units.

Mrs. Seager has taken an active part in professional activities. She was president of the Edmonton Chapter, AARN, 1957-59. Her off duty interests are varied. She is a member of the Alpine Club of Canada, the Sky Line Trail Hikers' Association and the Altrusa Club of Edmonton.

With the current developments in hospitalization programs, we welcome the appearance of a growing number of nurse consultants to interpret the views of our profession.

Frances Eileen Cole has been appointed to the Northwest Regional Hospital Council of Saskatchewan in the above capacity. A graduate of St. Paul's Hospital, Saskatoon, she obtained her diploma in administration of hospital nursing service from the University of Saskatchewan earlier this year. Since graduation she has served as a head nurse in St. Boniface Hospital and the Department of Veterans' Affairs Hospital, Saskatoon; a clinic nurse at the Saskatoon Cancer Clinic;

eitman's

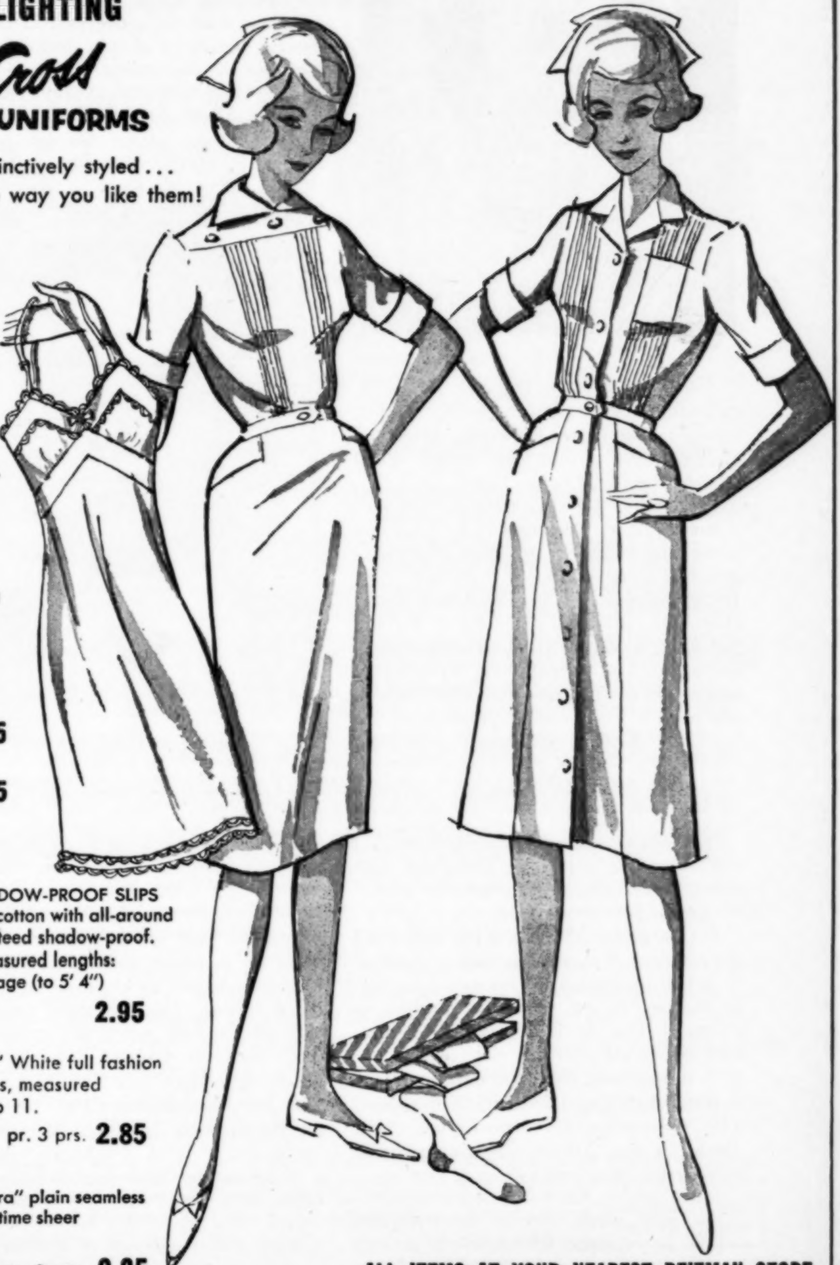
"WHERE SMART WOMEN SHOP"

'first stop' for
your professional wardrobe!

SPOTLIGHTING

La Cross
UNIFORMS

artly and distinctively styled . . .
iforms just the way you like them!



iforms illustrated,
ailable in
anforized"
er-poplin . . .
fabric with
lightful 'easy
shing and drying
nners' . . . an
eal choice for
p good looks
y-long.
Sizes 10 to 20,
4.95
Sizes 12 to 20,
3.95

UBLE SKIRT SHADOW-PROOF SLIPS
led in cool white cotton with all-around
ble skirt, guaranteed shadow-proof.
es 32 to 40 in measured lengths:
rt (to 5′ 2″) Average (to 5′ 4″)
l (over 5′ 5″)
2.95

ITMAN'S "Ballet" White full fashion
e, daytime sheers, measured
gths, sizes 8½ to 11.
.99 pr. 3 prs. **2.85**

ITMAN'S "Van Ultra" plain seamless
ons in White. Daytime sheer
izes 8½ to 11.
.99 pr. 3 prs. **2.85**

ALL ITEMS AT YOUR NEAREST REITMAN STORE,
or write to Reitman's Mail Order Dept.,
3510 St. Lawrence Blvd., Montreal 18, P.Q.

(Spencer's Studio)

EILEEN COLE

assistant head nurse, Lethbridge Municipal Hospital, and general duty nurse, Westminster Hospital, London, Ont.

Russel Earl Dagenais was appointed nursing counsellor to the Quill Plains Regional Hospital Council in February, 1960. He is a graduate of St. Elizabeth Hospital, Humboldt, Sask. with a diploma in teaching and supervision from the University of Saskatchewan. Mr. Dagenais was awarded the provincial Department of Public Health bursary for postgraduate preparation. He has had considerable experience in teaching and supervisory capacities since his graduation having served as clinical instructor in the operating room of his hospital for a year and then as classroom instructor and finally clinical instructor in medical nursing.

He has taken an active part in the professional activities of his alumnae association and is the present chairman of the Quill Plains Regional Nursing Council. In the past he served on the executive of the local chapter, SRNA. Off duty he takes an active interest in community affairs.

RUSSEL DAGENAIS

"How to Observe Nursing Activities," a two-part black and white filmograph with sound, is available to hospitals and schools for loan or purchase.

The purpose of the filmograph is to teach the technique of observation used in research. Part I gives step-by-step instruction on how to observe, record and code activities of personnel. Part II deals entirely with situations which are somewhat more complex and consequently more difficult to code.

Write to Film Librarian, Audio-Visual Unit, Communicable Disease Center, Public Health Service, Atlanta, Georgia, specifying a preferred and alternate showing date.

* * *

An open mind, like an open window, should be equipped with a screen to keep the bugs out. — Journal of Phi Rho Sigma

Not all crying of infants is hunger, gas or gastro-intestinal dysfunction. Many cry seeking only human contacts, pleasant and harmonious sounds, and the warmth and security of being held in arms. Surely there is no sin in taking an infant in the arms, rocking in a rocking chair and softly singing a lullaby. This has cured more colic than all the tidal waves of "green drops" that have been squirted down throats of struggling infants.

— Journal of the Louisiana State Medical Society, December, 1959.

* * *

Wrinkles should merely indicate where smiles have been. — MARK TWAIN

* * *

Don't fear the frown of a critic or try to make him smile at you.

over an 8-year span...

VIRTUALLY NO DECREASE IN STAPHYLOCOCCAL SENSITIVITY

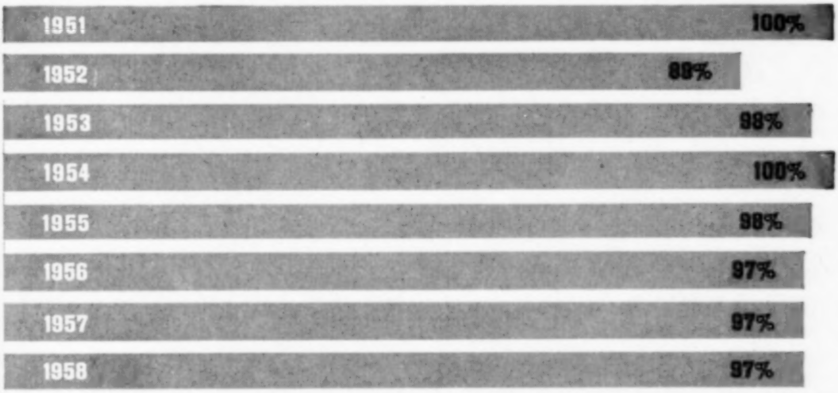
CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Rebhan and Edwards,[1] reporting from the Hospital for Sick Children, Toronto, observe that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug.

In Canada,[1-5] as in every other country in the world, published reports repeatedly confirm the efficacy of CHLOROMYCETIN in a wide variety of serious infections.

IN VITRO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



Statistics were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed. As with virtually every other study reported, these results were obtained with CHLOROMYCETIN (Parke-Davis' brand of chloramphenicol).

*Adapted from Rebhan & Edwards[1]

Chloramphenicol is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16, 100, and 1,000.

References: (1) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (2) Editorial Comments: *Canad. M. A. J.* 82:537, 1960. (3) Brownrigg, G. M.: *Canad. M. A. J.* 73:787, 1955. (4) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844, 1957. (5) Royer, A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783.

PARKE, DAVIS & COMPANY, LTD.
Montreal 9, P.Q.

PARKE-DAVIS

® REGISTERED TRADEMARK 37660

Book Reviews

Science Principles Applied to Nursing by Madelyn Titus Nordmark, R.N., B.S., M.S. (N.E.) and Anne W. Rohweder, R.N., B.S., M.N. 276 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 1959. Price $5.00.

Reviewed by Miss Beryl Seeman, Instructor, Grace Hospital, Winnipeg.

This book provides for the nurse-educator a wealth of simply stated facts gleaned from many fields of nursing.

Perhaps its scope, nature and quality may be comprehended from the following notes:

1. The studies upon which it is based were carried on over a period of five years.
2. Over 40 people contributed in one way or another to the compilation of material.
3. The approach to the preparation of the material is significant. In order to identify principles underlying nursing care, hypothetical patients suffering from many different conditions were studied. The total nursing care emphasizing the basic principles was outlined in each instance. The material was categorized to prevent repetition.
4. The manuscript was submitted to persons well versed in the scientific and clinical fields who criticized it before it went into final form.

There is a detailed introduction and a chapter outlining the possible usefulness of the book in nursing education. It could be used to help evaluate the attainment of objectives, as an example.

The main body of material is divided into two parts: principles of natural sciences; principles of social sciences. In the sections dealing with natural sciences, nursing care is outlined first in a brief, tabulated form. This is followed by the principles of anatomy and physiology, physics, and chemistry underlying such care. In dealing with social sciences, concepts are stated first, then the principles that derive from them and finally related nursing measures. One can ascertain a desired fact within a matter of seconds.

This book would be useful primarily for instructors. It could serve as a reference in preparing material in their own particular areas. It would also help them to grasp quickly and in greater detail the relationship of each area of student learning to the whole. The authors have remarked that the time allowed for the studies was limited so that some areas of nursing, such as the giving of medications, have not been covered.

This is a book that is difficult to review adequately. I feel that any nurse-educator would continue to find new values in it even after many months of use.

Professional Nursing by Eugenia K. Spalding, R.N., M.A., D.H.L. 694 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 6th ed. 1959. Price $6.00.

Reviewed by Mrs. Jane E. Mooney, Associate Director of Nursing Education, St. Paul's Hospital, Vancouver, B.C.

The first edition of this excellent book was called *Professional Adjustments in Nursing.* It was designed for use by senior students in schools of nursing offering a basic curriculum, under the guidance of an instructor who was responsible for coordinating their planned experiences. This edition is based upon studies made by the author among graduate and student nurses. These studies were carried out to determine the problems and needs of nurses. The book is intended to help both student and graduate to understand trends and problems in nursing. It is intended also, to serve as a guide to solving some of these problems so that the individual nurse may be able to make good personal and professional adjustments.

The objectives remain unchanged. The text should be of value to the junior student as the first two chapters describe nursing as a profession in its social setting. It could be a valuable addition to the library of a school counsellor as she guides young people in the choice of a profession.

Of particular interest to the more advanced student nurse are chapters five to nine. Various fields of practice open to nurses, the preparation and qualications required, the functions of the nurse, and the advantages and disadvantages of each of these fields are discussed in detail.

New topics, not usually mentioned in similar texts, are problem-solving, national student nurses' associations, minute-taking, and nurses in civil and defense mobilization. Especially well written is a chapter on international nursing organizations. The material concerning personal budgeting should be a great help to the young graduate.

The illustrations, both graphic and photographic, are skilfully used. The problems at the end of each chapter are pertinent. They should stimulate individuals and groups to

Sometimes the solution to the day's grind
simply adds up to a welcome "pause that refreshes"
with ice-cold Coca-Cola.

Say "Coke" or "Coca-Cola"—both trade-marks mean the product of Coca-Cola Ltd.—the world's best-loved sparkling drink.

To solve a special problem of the aged...

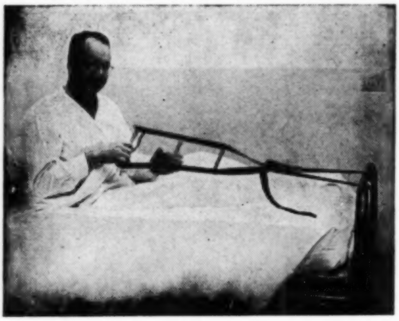
The soothing and healing properties of BAYSWATER GERIATRIC Ointment are invaluable in the treatment of skin irritations, dry eczema rashes, and any of the rashes which so often occur in later years. It is used by hospitals, nursing homes and public health nurses because of its effectiveness on irritated skin areas of the aged and incontinent.

RELIEVES IRRITATION OF ITCHING ASSOCIATED WITH VARICOSE CONDITIONS ON LEGS.

For free samples, write to:
BAYSWATER PHARMACAL COMPANY,
2941 West Broadway,
Vancouver, B.C.

BAYSWATER
GERIATRIC
Ointment
BAYSWATER
GERIATRIC
Ointment

BAYSWATER
GERIATRIC
OINTMENT



POSEY
PATIENT AID

A rehabilitation product which encourages self-exercise and is a positive aid to the geriatric No. B-654 (For open-end beds) No. B-654-A (For beds with solid foot ends) $5.95 ea.

J. T. POSEY COMPANY • 2727 E. FOOTHILL BLVD., PASADENA, CALIF.

---

further research and study, and attempts at problem-solving. The reference lists are especially useful because they are classified under important broad headings.

Completely omitted as a topic is leadership — how it may be developed and the responsibility of schools of nursing to develop this quality in their students.

This is an interesting, informative, up-to-date textbook. Though it was not intended as a guide to improve public relationships, it should be valuable in interpreting to allied professions and the general public just what the nursing profession is attempting to do to meet the needs of the public, and what problems we are encountering.

want to be wanted?

As every professional nurse knows, there can be satisfactions in service which are truly more important than salary or fringe benefits.

This is the principle which guides us at Syracuse Memorial Hospital, and one which can be important to every nurse making a career decision. (Our salaries do start at $4,000 for registered staff nurses, and all benefits are listed in a booklet that's yours for the asking.)

Nurses are wanted at Syracuse Memorial—now.

Nurses who are here feel wanted, always.

Want to know more about it? Write me today.

Esther Budd

want
to
be
wanted?

Syracuse Memorial Hospital
University Station, Syracuse 10, New York

A primary affiliate of the State University of New York Upstate Medical Center

CN-11

Miss Esther Budd, Director of Nursing
Syracuse Memorial Hospital
Syracuse 10, N. Y.

Please tell me more about Syracuse Memorial

______________________________, RN

____

______________________ ____________

REGISTERED NURSES

Transportation from Canada to U.S. destination paid by employer for nurses who meet professional qualifications for responsible hospital positions and immigration requirements before January 2, 1961.

Positions located in Kentucky and West Virginia. Mild winter climate. Apartment accommodations (modern furniture, complete kitchens, private baths) available near hospitals. For outdoor enthusiasts, golf, tennis, fresh water fishing.

Opportunities for professional growth in rural-industrial setting served by unique 10-hospital network. Modern equipment, full-time medical staff, including specialists.

Salaries $4,860 to $6,420 per year depending upon qualifications. Four weeks' vacation, 7 paid holidays, 40-hr. week, other benefits.

Inquiries especially welcomed from nurses with special interest in rehabilitation of the severely disabled and care of long-term patients.

Write or telegraph (collect)

IRENE HEALY, ASSOC. ADM. FOR NURSING SERVICE AND EDUCATION,
MINERS MEMORIAL HOSPITAL ASSOCIATION, BOX 61
(TELEGRAPH: 110 LOGAN ST.), WILLIAMSON, WEST VIRGINIA.

Price list for Reprints

A new edition of Dr. E. M. Watson's

Summary of Clinical Laboratory Procedures

is now available

Prices:

Single copies	15 cents
One dozen copies	$1.50
25 to 100 copies	10 cents each
Over 100 copies	8 cents each

Name ....

Address ....

No. of Copies ....

Amount Enclosed ....

EMPLOYMENT OPPORTUNITIES

ADVERTISING RATES

Canada & Bermuda — $7.50 for 3 lines or less; $1.50 for each additional line.

U.S.A. & Foreign — $10.00 for 3 lines or less; $3.00 for each additional line.

Rates for display advertisements on request.

All advertisements published in both English and French issues. Closing date for insertion or cancellation orders, SIX WEEKS prior to date of publication.

English issue published the first of each month.

Address correspondence to:

THE CANADIAN NURSE JOURNAL
1522 SHERBROOKE STREET WEST
MONTREAL 25, QUEBEC

ALBERTA

Registered Nurses or Graduate Nurses for General Duty (2) for new 25-bed hospital — **excellent working conditions.** Salary schedule according to suggested A.A.R.N. — namely $270 - $300 & adjusted according to experience since graduation. Living-in accommodation available at $30 per mo. Apply to: Matron, Municipal Hospital, Coronation, Alberta.

Registered Nurses for Fairview Municipal Hospital. Wages $300-$330, $10 extra for 11-7 shift. Apply: Mrs. P. Landry, Matron, Municipal Hospital, Fairview, Alberta.

Registered General Duty Nurse Salary $270 - $285 per mo., 1 mo. vacation with pay after 1-year service. Apply: Matron, Municipal Hospital, Raymond, Alberta.

General Duty Nurses (2) Salary $270 - $300 per mo. plus other benefits, 40-hr. wk., train fare from any point in Canada will be refunded if employed for 1-year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta. Phone 335.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

Graduate Nurses (4) for Maternity, Pediatrics, Medicine & Surgery. Wages $285 - $300 according to experience. Contact- Les Soeurs de la Charité de N.D. d'Evron Hôpital St. Louis, Bonnyville, Alberta.

BRITISH COLUMBIA

Director of Nursing for 109-bed B.C. Hospital. Salary open & dependent upon qualifications & experience. For full particulars, apply stating qualifications, to: Administrator, General Hospital, Prince Rupert, British Columbia.

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. **Graduate Nurses- B.C. Registered Nurses** starting $285 per mo., Graduate Nurses $270 per mo., 28-days annual vacation, 10 statutory holidays per year, accommodation available in new modern nurses' residence on hospital grounds. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

Supervisor (Evening & Night Service) for 110-bed hospital. Starting salary, 1960: $330; 1961: $357, more if experienced. For information apply giving qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Head Nurse for Pediatric Ward General Hospital with school of nursing. Able to assist with student teaching program. Salary based on experience and/or postgraduate preparation. Applications should be addressed to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Head Nurse for 48-bed **Pediatric Department** with postgraduate preparation in pediatrics & preparation &/or experience as head nurse. B.C. registration required. Salary: $305-$369. Credit for past experience & postgraduate preparation. Annual increments. 40-hr. wk. 28-day annual vacation, statutory holidays, cumulative sick leave. Apply to: Director of Nursing, Royal Columbian Hospital,, New Westminster, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Starting salary, 1960: $285; 1961: $312, more if experienced. Residence available. For particulars apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Registered Nurse for new 26-bed hospital in the Fraser Canyon 100-mi. east of Vancouver, B.C. Basic salary $285 — shift differential, 40-hr. wk., 28-calendar days' annual vacation. Accommodation available in a new nurses' residence. Positions available December 1st. Apply: Director of Nurses, Fraser Canyon Hospital **Hope,** British Columbia.

Registered Nurses (3) for Queen Charlotte Islands General Hospital. Assistance in travelling expenses & salary approved by provincial nurses' association is offered. This is an opportunity for service in a home mission hospital operated by the United Church of Canada. Apply to: Hospital Administrator, Queen Charlotte City, British Columbia.

Registered Nurses for 105-bed modern hospital. Starting salary $285; four 5% annual increments; 28 days vacation after 1 years' service, 1½-days sick leave per mo. cumulative to 120-days. Accommodation in residence available. For further particulars write: Mrs. L. Thom, Superintendent of Nursing, Jubilee Hospital, Vernon, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospitals. Personnel policy in accordance with R.N.A.B.C. Rooms available in nurses' residence. Nurses Aides (with vcational training). Salary: $177 - $201 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses Salary $285 per mo., increase of $12 after 1-yr. service. Charge for room, board & laundry $40; all statutory holidays paid, 28-days vacation after year's service. Graduate complement six (6). Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $285 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

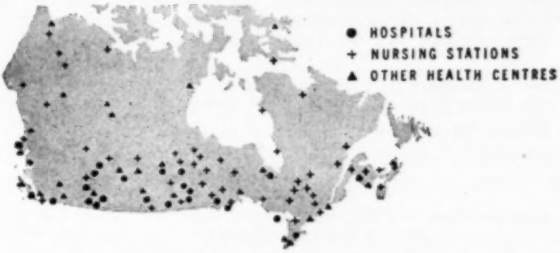
Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Operating Room Nurse with postgraduate course for active operating room in General Hospital with School of Nursing. Salary $285 plus increment for experience. Must be eligible for B.C. registration. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Operating Room Nurse for 109-bed hospital in northern B.C. Salary $285-$342 plus on call pay, 1961 salary $312-$374, P.G. $10 extra. Room & board $50 per mo., travel allowance, welfare plan. Apply stating qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Operating Room Nurses with postgraduate training & **General Duty Nurses** for 450-bed hospital. B.C. registration required. Salaries & personnel policies in accordance with R.N.A.B.C. Apply: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES
REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for positions in Hospitals, Outpost Nursing Stations and Health Centres in the Provinces, Eastern Arctic, Northwest and Yukon Territories.

SALARIES

(1) Public Health Nursing Supervisor II —$5,100 to $5,460 per annum

(2) Public Health Nursing Supervisor I —$4,620 to $5,160 per annum

(3) Directors and Assistant Directors of Hospital Nursing Services:
  a) Classification III —$4,860 to $5,400 per annum
  b) Classification II —$4,350 to $4,860 per annum
  (c) Classification I —$3,900 to $4,560 per annum

(4) Public Health Staff Nurses —$3,600 to $4,050 per annum

(5) Hospital Staff Nurses —$3,300 to $3,750 per annum

(6) Certified Nursing Assistants, Licensed Practical Nurses and Nurses' Aides: up to $2,400 per annum depending upon qualifications and location of positions.

- **Room, board and laundry in residence at reasonable rates. Statutory holidays. Three weeks annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.**
- **Special pay and leave allowances for those posted to isolated areas.**

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.
(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.
(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.
(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.
(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.
(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.
(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.
(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

MANITOBA

Science Instructor for school of nursing, 150-bed General Hospital. **Registered Nurse** with postgraduate education preferred for courses in Anatomy-Physiology, combined Microbiology-Bacteriology, and Pharmacology. Duties to commence immediately. Apply in writing to: Personnel Officer, General Hospital, Brandon, Manitoba.

Registered Nurses (2) Position of Matron will become vacated approx. April 15th. 1961, at the Glenboro Medical Nursing Unit 16B. Applications from R.N.'s with a view of being appointed Matron will be welcomed. Starting salary for R.N.'s $295 per mo., liberal sick leave & vacation benefits. 40-hr. wk. Glenboro is located 100-mi. west of Winnipeg, & 50-mi. east of Brandon on No. 2 Highway. Hospital is approx. 5-yrs. old, & nurses' residence was built in 1959. Apply to: Mr. S. A. Oleson, Box # 310, Glenboro, Manitoba.

Registered Nurse for General Duty. Starting salary $290 per mo., 6 increments of $5.00 at 6-mo. intervals. Board & room $45 per mo. For further information, phone: Boissevain 61.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District # 18, Portage La Prairie, Manitoba.

NOVA SCOTIA

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing for new 150-bed General Hospital just completing new addition. Certified Nursing Assistants' training school planned. Hospital located in large resort area. Apply giving full particulars & salary expected, to: Administrator, Ross Memorial Hospital, Lindsay, Ontario.

Nursing Supervisor qualified to assist Director of Nursing. Degree in public health administration is essential. Excellent salary & fringe benefits available including pension & car allowance. Apply in writing to: Personnel Director, Township of Scarborough, 2001 Eglinton Avenue East, Scarborough, Ontario.

Head Nurses & General Duty Nurses vacancies on nursing floors & in the Operating Room. Excellent salaries & conditions of service in popular winter & summer resort area. Write to: Director of Nurses, General Hospital, Parry Sound, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses Applications & enquiries are invited for General Duty positions on the staff of modern, well-equipped 33-bed hospital in new mining town, about 250-mi. East of Port Arthur & North-West of White River, Ontario. Excellent salary & fringe benefits, liberal policies regarding accommodation & vacation. Population 2,500. Nurses' residence comprises individual self-contained apartments. Apply, stating qualifications, experience, age, marital status, phone No. etc., to: The Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Deduction for room & board $30. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

WORLD HEALTH ORGANIZATION

requires experienced Nurse Educators for senior adviser posts in:

1) **SIERRA LEONE and GHANA** To help plan basic and post-basic nursing education programs, based upon surveys of local needs.

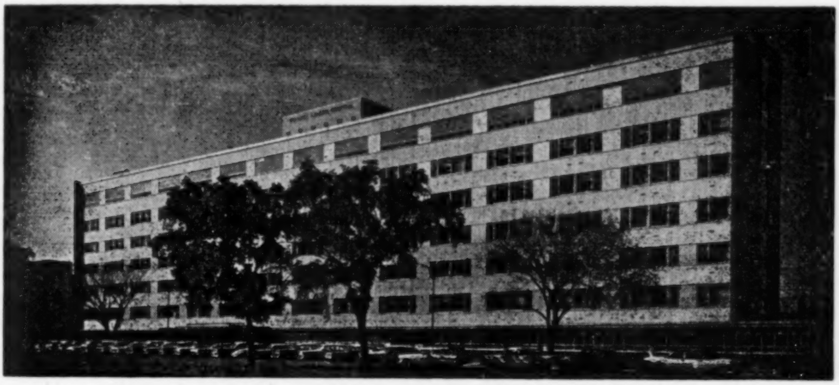
2) **IRAN** Basic 3-year school of nursing.
The salary range for each of these posts is US $6,000 - $8,000 per annum (net of tax), plus allowances.

3) **TAIWAN** University School of Nursing: basic and post-basic programs.
The salary range for this post is US $7,300 - $9,500 per annum, (net of tax), plus allowances.

Initial contracts are for two years. Travel to and from duty stations is paid by the Organization. Paid home leave may be taken at 2-year intervals, subject to renewal of contract.

Applications may be made to:

PERSONNEL OFFICE, WORLD HEALTH ORGANIZATION,
PALAIS DES NATIONS, GENEVA, SWITZERLAND



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $270, 40-hr. wk., 14 days sick leave, 8 statutory holidays, 4-wks. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse**, starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan.** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury.** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses for 76-bed General Hospital in small town, 16-mi. from Sarnia. Good personnel policies in effect. Limited residence accommodation available. Apply to: Administrator, Charlotte Eleanor Englehart Hospital, Petrolia, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital. Fort Erie, Ontario.

General Duty Nurse Starting salary $270 per mo. **Charge Nurse** salary $300 per mo. for 50-bed hospital, resort area. 5-day wk. Apply: Administratrix, Huntsville District Memorial Hospital, Huntsville,, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $270 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

TORONTO GENERAL HOSPITAL

REQUIRES

Registered Nurses and Certified Nursing Assistants

for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units

Rewarding Experience — Excellent Personnel Policies

For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

REGISTERED NURSES

Enjoy Sun, Surf and Sand the year round in beautiful San Pedro near the Pacific Ocean in Southern California, one-half hour drive from the heart of Los Angeles.

Immediate positions available for General Duty nurses on all services and shifts in Community Hospital. Opening of new modern 140 bed building will create even many more attractive positions in early January, 1961.

Starting salary $345 per month for day shift; $355 for evening and night shift, with $10 additional for surgery and obstetrics. Yearly increases for four years. Liberal personnel policies include cumulative sick leave, seven paid holidays per year, Blue Cross Insurance available, plus two weeks' vacation after one year and three weeks after five years' employment. Contact:

DIRECTOR OF NURSES, SAN PEDRO COMMUNITY HOSPITAL,
1305 W. 6TH STREET, SAN PEDRO, CALIFORNIA

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Staff Nurses & Certified Nursing Assistants for surgical, medical, obstetric & pediatric departments. Comparable personnel policies. Well planned orientation & in-service programs. Apply: Director of Nursing, Toronto East General Hospital, Coxwell at Sammon Ave., Toronto 6, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses (Qualified) Generalized program includes some bedside nursing. Salary $3,500 - $4,500; annual increment $200, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses with certificate. Benefits include pension, hospital & medical coverage, vacations & statutory holidays. Salary range $3,630 - $4,174 per year plus car allowance.Apply in writing to: Personnel Director, Township of Scarborough, 2001 Eglinton Avenue East, Scarborough, Ontario.

Public Health Nurse (Qualified - Catholic) for St. Elizabeth Visiting Nurses' Assn. Minimum salary: $3,600, annual increment. 5-day wk., 4-wk. vacation. $100 uniform allowance. Pension, P.S.I., Blue Cross. Apply: Director, 67 Bond Street, Toronto, 2, Ontario. EM. 8-1863.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Graduate Nurses & Certified Nursing Assistants: Immediate positions available in Medical, Surgical & Obstetrical units. Salaries in accordance with scale recommended by Provincial Nurses' Association. Attractive personnel policies. Apply to: Director of Nursing Service, St. Mary's Hospital, Montreal 26, Quebec.

General Duty Nurses for Obstetrical Service. Apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

SASKATCHEWAN

Operating Room Supervisor with postgraduate training, for 180-bed hospital. Average monthly surgical load - 157. Basic Salary $335 per mo. Duties consist of administration of department & educational program of students in department. Apply stating qualifications & experience to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Obstetrical Supervisor for 225-bed General Hospital, good personnel policies. For further information contact: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses (2) for 19-bed hospital at Vanguard, Sask. Salary range $280 - $355. One year's experience $295 - $355. 3-wk. vacation, sick leave, residence on grounds with T.V. Apply to: The Secretary, Vanguard Union Hospital, Vanguard, Saskatchewan.

Registered Nurses for General Duty in Medical & Surgical Wards. Salary $270-$345, good personnel policies & liberal holiday allowance. Apply: Director of Nursing, Providence Hospital, Moose Jaw, Saskatchewan.

Residence, Cook County School of Nursing

NURSES WHO LIVE
HERE NEVER STOP
LEARNING . . .
GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest
Most Stimulating Medical
Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a 37½ *hour week.* And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

OPERATING ROOM NURSES

For expanding 374 bed General Hospital located on Long Island Sound just 45 minutes from New York City.

- Starting salary $355, annual increases for four years.
- $15 bonus paid for each night on call.
- Paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.
- Scholarship aid available for continued collegiate study.

Apply: Operating Room Supervisor

NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living accommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accumulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

Registered General Duty Nurses (2) for modern 7-bed company hospital. Salary $315 per mo., $10 accredited postgraduate courses, overtime paid, $25 increment after 1 year. Full maintenance, transportation paid from point of hire in exchange for 1 year service. Group insurance & attractive vacation benefits. Excellent recreational facilities, boating, fishing, swimming, bowling, etc. Apply: Miss N. Prefontaine, R.N., Matron, Gunnar Mines Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses — You can come to California & make $375 per mo. as a staff nurse. Openings are now available on the Obstetrical, Medical & Surgical Services. If you speak & write English & are eligible for California registration, write us for full details: Evelyn Nina Spees, R.N., Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

Registered Nurses (Come to sunny California) **Staff & Supervisory permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40-hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Attention! General Duty Nurses 400-bed fully accredited County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, paid holidays, pd. sick leave, retirement plan, social security, & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Increase in 6-mo. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses — San Joaquin General Hospital, a teaching hospital with internes, residents, & school of professional nursing. Positions available on most services on all shifts. Starting salary $376 per mo., differential for evening & nights. Laundry uniforms $5.00 per mo., liberal personnel policies, living facilities for single persons on hospital grounds. Contact: Personnel Director, 732 East Main Street, Stockton, California.

DIRECTOR OF NURSING

The Toronto General Hospital is accepting applications for the position of Director of Nursing.

The Toronto General is a 1450-bed hospital with an enrolment in the School of Nursing of approximately 300.

It is a teaching hospital associated with the University of Toronto.

Applications should be directed to:

THE SUPERINTENDENT
TORONTO GENERAL HOSPITAL,
101 COLLEGE STREET,
TORONTO 2, ONTARIO.

Applications will be considered confidential

ALUMINUM COMPANY OF CANADA, LIMITED

requires

INDUSTRIAL NURSE

for medical department, Kitimat Works. Must be eligible for or obtained B.C. registration. Previous experience in industrial plant an asset. Full employee benefits.

Applications may be obtained by writing to:

THE EMPLOYMENT SUPERVISOR,
ALUMINUM COMPANY OF CANADA, LIMITED,
BOX 1800, KITIMAT,
BRITISH COLUMBIA

MONTREAL CHILDREN'S HOSPITAL

invites applications for the position of Assistant Director of Nursing Service

Must hold qualifications for registration in Quebec.

University Degree in Administration preferred, experience in supervision necessary. Salary dependent upon qualifications & experience, Good personnel policies with 4-weeks annual vacation & pension plan.

For further information, address inquiries to:

DIRECTOR OF NURSING
MONTREAL CHILDREN'S HOSPITAL
2300 TUPPER STREET
MONTREAL, QUEBEC

REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS' HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg.
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $330 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: **$365** for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Good salary, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N's. $58 per wk. Experience considered, differentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101 Hall of Records Building, Fresno 21, California

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of Nurses, General Hospital, Tulare, California.

ONTARIO

Director of Nursing for 50-bed hospital in beauty spot of lakes & rivers, cooperative & pleasant staff. 5-day wk., pension plan, salary commensurate with experience. Apply: Administrator, Huntsville District Memorial Hospital, Huntsville, Ontario.

JOSEPH BRANT MEMORIAL HOSPITAL

1240 NORTH SHORE BLVD.,
BURLINGTON, ONTARIO.

This modern General Hospital will be ready for occupancy in early 1961.

Applications are invited for Supervisory and Staff positions in nursing service.

Opportunities are available for Registered Nurses and Certified Nursing Assistants in pediatrics, obstetrics, medicine, surgery, operating Room, and central supply.

Apply to the

DIRECTOR OF NURSING

SPEECH THERAPIST TRAINEES

Bursaries are available for individuals wishing to enrol in a Diploma Course in Speech Pathology and Audiology and upon graduation to be employed by the Nova Scotia Society for the care of Crippled Children.

Applicants should be graduates of an Approved School of Nursing or should hold a Bachelor's degree, preferably in Education, from a recognized University.

For further information, apply to:

THE EXECUTIVE DIRECTOR
THE NOVA SCOTIA SOCIETY
FOR THE CARE
OF CRIPPLED CHILDREN
P.O. BOX 331, HALIFAX
NOVA SCOTIA

KINGSTON GENERAL HOSPITAL

requires

GENERAL DUTY NURSES

for:

Medical, Surgical Floors
and Intensive Care Unit
(male or female Registered Nurses considered for all above positions)

Certified Nursing Assistants

Trained psychiatric attendants (F)

For full details relating to hours, vacations and benefits, apply to:

DIRECTOR OF NURSING,
KINGSTON GENERAL HOSPITAL,
KINGSTON, ONTARIO

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for

INSTRUCTORS

in Medicine, Surgery and Pediatrics
by July 15th, 1961.

Qualified applicants are invited to apply.

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

JEWISH GENERAL HOSPITAL
MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Instructor with post basic preparation in Nursing Education required for School of Nursing. Excellent personnel policies. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

BRITISH COLUMBIA

Registered Nurses for modern active 25-bed hospital on beautiful Lake Windermere in the Canadian Rockies. Excellent recreational facilities all yr. 90-mi. from Banff & Lake Louise. Policies according to RNABC. Basic salary: $285 per mo. Excellent residence accommodation with full maintenance: $50 per mo. Apply: Matron, Windermere District Hospital, Invermere, British Columbia.

Graduate Nurses (4) immediately for 40-bed hospital. Salary $300 per mo. for B.C. Registered Nurses & $15 less per mo. for non-registered nurses. 3 yearly increments, 40-hr. wk., 1½-days sick leave with pay per mo., 28-days vacation with pay after 1-year of employment & 10 legal days per year. Fare from anywhere in Canada advanced & need not be repaid if you stay 6-months. Superannuation benefits, uniforms are laundered gratis by the hospital. There is a new modern residence which is available for $45 to $50 per month. Interesting social advantages as an excellent Choral Group, excellent educational opportunities and good sporting, Skating, Bowling, Fishing, Boating, Curling, Hunting, etc. Kindly apply giving references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

MANITOBA

Registered Nurses (2) immediately; for 10-bed hospital. Salary $310 with increments every 6-mo. Full maintenance $45, 5-day wk., month vacation with pay following years' service. Apply: Secretary, Benito Hospital, Benito, Manitoba.

General Duty Nurses for Clearwater Lake Hospital, The Pas, Manitoba. Interesting nursing with White, Indian & Eskimo patients both in general & tuberculosis wards. Starting salary $300 per mo. Good accommodation in nurses' residence. 3-wk. vacation, 40-hr. wk., 10 statutory holidays, group insurance plan. Apply: Director of Nursing Services, Sanatorium Board of Manitoba, 1654 Portage Avenue, Winnipeg, Manitoba.

NOVA SCOTIA

Registered Laboratory Technician. Good personnel policies. Apply stating experience & qualifications, to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

Operating Room Nurse — 40-hr. wk., good starting salary. Apply to: Director of Nurses, Western Kings Memorial Hospital, Berwick, Nova Scotia.

ONTARIO

Director of Nursing for 80-bed General Hospital, 20-mi. from London. New Hospital to be built early in 1961. Excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, or phone collect. Strathroy, Ontario.

General Duty Staff Nurses for 80-bed hospital, 20-mi. from London. Accommodation available in residence, excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, Strathroy, Ontario.

General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time allowance. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.

Nurses (2) for United Church Mission Hospital in northern British Columbia. Salary $285 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia. or** Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Avenue East, **Toronto, Ontario.**

P.E.I.

Director of Nursing Education, degree preferred, **Medical-Surgical Clinical Instructor, Nursing Arts Instructor,** for school associated with 200-bed hospital, salary based on qualifications & experience. Apply to: Director of Nursing, Prince Edward Island Hospital, Charlottetown, Prince Edward Island.

QUEBEC

Operating Room Nurses for modern well-equipped department in 140-bed General Hospital, no rotation, but required to take night calls. Good personnel policies & salary in accordance with ANPQ recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

MRS. COWARD'S TRAINED NURSES INSTITUTE

62, St. George's Square, London, S.W.1, England
Founded 1904

VACANCIES ARE AVAILABLE FOR SELECTED STATE REGISTERED NURSES WHO DESIRE TO UNDERTAKE PRIVATE NURSING.

The Institute, established for over 50 years as a non-profit making venture, offers nurses the advantage and comfort of facilities at its premises; also board and residential accommodation at moderate prices.

Full particulars as to remuneration, etc. may be obtained on application to the Sister-in-Charge at the above address.

Before leaving Canada nurses should apply for English registration to the General Nursing Council for England and Wales (23 Portland Place, London W.1.)

GENERAL DUTY NURSES

$335 per month, annual increment $10 monthly. 40-hour week, paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.

Scholarship aid available for continued collegiate study.

Apply: Superintendent
ALEX. E. NORTON
NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

DAY - SUPERVISOR

With opportunity for advancement to Superintendent of Nurses
for Clearwater Lake Hospital, The Pas, Manitoba

Well equipped 160-bed hospital with general and tuberculosis patients. Attractive salary, commensurate with experience and qualifications. Good residence accommodation and excellent personnel policies. For information and application apply:

Director of Nursing Services
SANATORIUM BOARD OF MANITOBA,
1654 PORTAGE AVENUE, WINNIPEG 12, MANITOBA

CLINICAL INSTRUCTOR

FOR OPERATING ROOM

NEW ROCHELLE HOSPITAL
NEW ROCHELLE, NEW YORK

•

B.S. DEGREE REQUIRED

•

Salary depending on experience

APPLY TO: OPERATING ROOM SUPERVISOR

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available. Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation. Salary $285 - $342 per month with consideration for experience or special preparation.

Please apply to:

**PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW
STREET, VANCOUVER 9,
BRITISH COLUMBIA.**

ADVISER TO SCHOOLS OF NURSING

**The Saskatchewan Registered
Nurses' Association**

invites applications for the position of

ADVISER TO SCHOOLS OF NURSING

Applicants must possess a degree in nursing and have a minimum of five years experience in nursing education and nursing service of which the major portion has been in nursing education.

Apply in writing stating qualifications, experience and salary expected to:

**MISS LOUISE MINER,
PRESIDENT, S.R.N.A.
5 BARTLEMAN APT.,
REGINA, SASKATCHEWAN.**

A job description is available

DIRECTOR OF NURSING

Director of Nursing wanted. Modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan and direct education of (300 Student Nurses) and service programs. Perquisites include suite with service, pension plan, four (4) weeks vacation, sick benefits. Salary $7,000 - $9,000 annually depending upon qualifications and experience. Duties to commence as soon as possible.

Address replies to:

**CHAIRMAN, CALGARY HOSPITALS BOARD,
CALGARY GENERAL HOSPITAL, CALGARY, ALBERTA.**

ONTARIO

Assistant Superintendent, Registered Nurse for 75-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Instructor for Certified Nursing Assistant Course to begin about January 1st. 1961. Apply: Director of Nursing, Freeport Sanatorium, Kitchener, Ontario.

Registered General Duty Nurses for 34-bed General Hospital. Good salary & personnel policies, 40-hr. wk. Adjacent attractive residence, recreation facilities. For further particulars, apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 75-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305, for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

BRITISH COLUMBIA

General Duty Nurses (2) for 31-bed hospital, 4-hrs. from Vancouver. $300 per mo. for 42-hr. wk., free laundry, full board & private room in nurses's residence $45, 28-days vacation with 10-stats. & sick leave. Many recreational activities in beautiful sunny interior of B.C. Apply: Director of Nursing, General Hospital, Princeton, British Columbia.

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $387 - $507 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,
IROQUOIS FALLS, ONTARIO.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.

Partial fare refund after 1 yr. in service.

WRITE:

DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education
Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE RD., WINDSOR, ONT.

ASSISTANT DIRECTOR

Applications are invited for an Assistant Director of the Extension Course in Nursing Unit Administration. This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Qualifications: University preparation in teaching and supervision is necessary with several years experience in a supervisory position. Fluency in the French Language is desirable but not necessary.

For further information write to:

Director, Extension Course in Nursing Unit Administration,
CANADIAN HOSPITAL ASSOCIATION
25 IMPERIAL STREET, TORONTO 7, ONTARIO.

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

CALIFORNIA

REGISTERED NURSES

General Duty $4,440 up. Modern 130-bed General Hospital. In-service and paid hospitalization,—PLUS. Transportation reimbursed after 1 year.

Call or write:

DIRECTOR OF NURSING SERVICE,
GREATER BAKERSFIELD MEMORIAL HOSPITAL,
P.O. Box 26
BAKERSFIELD, CALIFORNIA.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

GENERAL DUTY NURSES

required by

The Dauphin General Hospital Ultra-modern 100 bed hospital in process of construction located in the beautiful Riding Mountain Resort area of Manitoba. 40 hour week, excellent personnel policies. Residence facilities, minimum starting salary $280 per month, assistance with transportation given if necessary.

Apply to: Superintendent of Nurses

DAUPHIN GENERAL HOSPITAL
DAUPHIN, MANITOBA

OPERATING ROOM TECHNICIANS

THE MONTREAL GENERAL HOSPITAL

would welcome applications for operating room technicians

Please apply to:

THE DIRECTOR OF NURSING,
THE MONTREAL GENERAL HOSPITAL,
1650 CEDAR AVE.,
MONTREAL, QUEBEC.

NEW MOUNT SINAI HOSPITAL
Toronto

Modern 400-bed Hospital

requires

REGISTERED NURSES

and

Certified Nursing Assistants

40-hour week - Pension plan

Good Salaries and Personnel Policies

Residence Facilities Available

Apply

DIRECTOR OF NURSING
NEW MOUNT SINAI HOSPITAL
550 UNIVERSITY AVENUE
TORONTO

PROVINCE OF ALBERTA

EMPLOYMENT OPPORTUNITY

GENERAL DUTY NURSES

Salary - $3,480. to $4,080. per annum. 40-hour week, Civil Service holiday, sick leave and pension programs.

DEPARTMENT OF PUBLIC HEALTH
Baker Memorial Sanatorium
Calgary, Alberta

Apply, giving full details, to the Baker Memorial Sanatorium, Calgary, Alberta.

DIETITIAN REQUIRED

Applications are invited from qualified dietitians for appointment to the post of Chief Dietitian at the Tuberculosis Sanatorium, St. John's, Newfoundland.

Salary commences at $3,900 per annum, on the scale of $3,900-100-$4,140 from which $710 per annum is deducted for board & lodgings.

Uniforms & laundry services are provided.

Interested applicants are invited to write giving full details as to experience etc., to the:

SUPERINTENDENT,
ST. JOHN'S SANATORIUM,
ST. JOHN'S, NEWFOUNDLAND

Transportation will be provided to Newfoundland for the successful applicants.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

OTTAWA CIVIC HOSPITAL

1300 bed General Hospital
with new 300 bed unit

invites applications from

REGISTERED NURSES

Good personnel policies

Apply to:

ASSISTANT ADMINISTRATOR — NURSING,
OTTAWA CIVIC HOSPITAL,
OTTAWA, ONTARIO.

PUBLIC HEALTH NURSES

FOR
Generalized program
IN
Seaway Development Area
Usual benefits, Pension Plan, allowance for experience

Apply to:

DR. PAUL S. deGROSBOIS, M.O.H.
HEALTH UNIT
26 PITT STREET
CORNWALL, ONTARIO.

GENERAL DUTY NURSES
WANTED

Salary — $265 - $315 per month 40-hour week, no split shifts

Vacation — 3 weeks after one year; statutory holidays — eight (8); sick leave — cumulative from date of employment

Transportation — advanced on repayable basis For 75-bed fully accredited hospital built in 1956, located in south-western Ontario.

Apply to: Director of Nursing,
SYDENHAM DISTRICT HOSPITAL
WALLACEBURG, ONTARIO

REGISTERED NURSES REQUIRED

(General Duty)

Modern 52-bed hospital 50 miles from Ottawa in the heart of holiday resort area has openings. Commencing salary $240 per month ($10 extra night duty two weeks) all statutory holidays from employment date, three weeks annual vacation, straight 8-hour day, 5-day (40-hour) week.

Private accommodation in luxurious new residence with full board and all facilities including laundry. $25 per month only.

Apply
DIRECTOR OF NURSING,
PONTIAC COMMUNITY HOSPITAL
SHAWVILLE, QUEBEC

ASSOCIATE DIRECTOR OF NURSING

CALGARY GENERAL HOSPITAL

invites applications for the position of Associate Director of Nursing, Modern 750-bed accredited civic General Hospital (200 bed addition being built). Duties to commence as soon as possible. Salary range $5,000 - $6,500 per year depending upon qualifications and experience. Liberal benefits and personnel policies.

Address replies to:
ADMINISTRATOR,
CALGARY GENERAL HOSPITAL,
CALGARY, ALBERTA.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON,
TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

SUPERVISOR FOR NEW PSYCHIATRIC UNIT TO BE OPENED IN FROM FOUR TO SIX MONTHS.

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO